

**Medicaid Study Group
Recommendations
September 23, 2015**

The Medicaid Study Group includes over a dozen Connecticut independent consumer advocates representing diverse populations and issue areas. The Group formed early in 2015 in response to a request from the Co-Chairs of the Care Management Committee of the Connecticut’s Medical Administration Program Oversight Council. Members of the Committee were asked to consult with their colleagues to give guidance to the Department of Social Services in redesigning our state’s Medicaid program to incorporate a shared savings payment model (Medicaid Quality Improvement and Shared Savings Program, MQISSP). The Group researched the available literature, other state Medicaid programs, and the experience of other shared savings programs, among other sources. The Group’s recommendations follow:

Note – throughout the document “network” refers to both Advanced Networks and Federally Qualified Health Centers (FQHCs) as described by MQISSP

Administration, Governance

- As required under federal law and guidance from the federal Centers for Medicare and Medicaid Services (CMS), consumers are free to choose their own providers at any time. Consumers must be notified when they are connected to a provider, and notified of their rights. Any marketing or administrative efforts by networks or providers to steer or confuse consumers about this right must be vigorously monitored and aggressively penalized.
- Consumers must be fully informed about shared savings, both the risks and benefits, what it could mean for them individually, and how to protect themselves as necessary, through both posted notices and mailed flyers. Consumer information must be effective, consistent, relevant and available both in advance and at the point of care. At a minimum, the information should inform consumers that, under this system, their providers are benefit financially if they reduce the total cost of their consumers’ care; that these financial incentives could result in restricted access to appropriate care in some cases, and that they have a right to ask questions about this and to file a complaint if they believe that this has occurred.
- In the (Request for Proposal) RFP response, networks must detail how they will support and protect the current, successful PCMH program in Connecticut Medicaid. Networks must make every effort to identify potential policies and procedures that could undermine the current program, both internal and external to the network, and describe how they will monitor and mitigate these risks.
- Consumers should be first able, though not required, to choose their primary care provider through an attestation process. If the chosen provider’s panel is

closed, the patient will either select a different provider or be attributed to a provider based on the majority of prior visits. Consumers who do not pick a primary care provider through attestation will be assigned based on their history of visits.

- Consumers must be attributed to their provider/network at the beginning of the contract period, rather than the end. Ensuring that providers know from the outset the group of people they are responsible for reduces incentives to drop “difficult” or “less lucrative” consumers.
- Public reporting on all aspects of the shared savings model is critical to accountability and improvement. Reporting must include but not be limited to the full nature of underservice findings, appeals, corrective actions, and resolutions.
- The state and networks must both support and encourage peer review of patient cases to monitor for inappropriate care, both patterns and individual cases. Providers who notify officials of inappropriate care should be rewarded and must be protected from retribution, professionally and personally.
- The state must expand mystery shopper surveys. They are critical to identifying adverse selection and other access problems that may increase in a shared savings model. Not every problem will be identified from claims data.
- All networks should eventually be recognized by an independent, national certification authority as Accountable Care Organizations.
- Only non-profit organizations should be eligible as a network lead agency. Preference in the selection process should be given to community organizations
- Preference should also be given to arrangements that will result in more than one network serving each community. Competition offers more consumer choice and better accountability.
- A network lead entity cannot be a managed care organization (MCO) or insurer and networks cannot have any ownership interests by an MCO, insurer or any related entity.
- Network governing Boards of Directors must include
 - At least two Medicaid consumer members attributed to the network, chosen by election of Medicaid consumer members of the network
 - Practicing care managers, not supervisors
 - Representatives of social service agency community network partners, i.e. housing, education, food/nutrition, local health departments
- Board members must agree to very strong conflict of interest policies that preclude voting on issues that impact their compensation, directly or indirectly, and they must recuse themselves completely from any such discussion.
 - Recruit independent, non-conflicted medical and non-medical community representatives to serve on the Board.
 - The Board can create ad hoc working groups with outside members for specific tasks to advise the Board and get outside input from interested/potentially conflicted stakeholders in public comment. There

are many functioning such models of ethical policymaking, both in Connecticut and from other states.

- Each network shall create a Community Advisory Council of independent, non-provider, non-investor consumers to advise the network
 - Each Council must have regular, scheduled public meetings, with minutes publicly available
 - The network must create a definition of “independent” consumer qualifications, and an independent process to appoint members.
 - There must be a link of at least two members that are on both the Board and the Consumer Advisory Council
 - The Board must consider and vote publicly on all recommendations from the Consumer Advisory Council
- Each network shall create a Community Improvement Plan
 - In a public process, engaging a broad spectrum of medical and non-medical community representatives
 - In collaboration with other local needs assessments including local health departments, hospital community health needs assessments, biannual regional mental health needs assessments
 - The Plan must include an analysis of local health quantitative and qualitative data, a methodology for determining priorities, specific action steps with identified responsibilities and resources for each
- The state must monitor the impact of MQISSP on
 - Connecticut’s successful Person-Centered Medical Home (PCMH) program, PCMH providers and consumers – in and outside MQISSP networks
 - Safety net services
 - Market, access, steering and patient choice
 - Access to out-of-network providers
- It is critical that the state devote generous resources to an independent monitoring and tracking, program necessary to evaluate MQISSP. Due to potentials conflicts of interest and other priorities, this function cannot be left to the networks.
- An effective state grievance policy and system is necessary, but not sufficient to protect consumers from harm in shared savings. The process to file a grievance must be private and easy to understand. There must be multiple means to inform consumers about their right to file a grievance and consumer surveys should be used to ensure that consumers are aware of the process. Consumers must be assured that their personal information will not be shared with the subject of their grievance and they will be protected from any repercussions. The state must follow up with consumers regularly on the progress of their grievance, offer them an opportunity for input on any resolution and notify them of the final decision. Information about grievances filed must be publicly reported.

- Both the state and networks must make consumers' data privacy and security the highest priority. Data can only be shared as needed for treatment, payment and to improve the quality of care. Data can never be sold or shared outside the state or the network, including corporate partners.
- Learning collaboratives should be structured to ensure they are effective and meaningful, to share best practices (over proprietary concerns), and promote best practices and connections with communities.

Payment, financing

- Shared savings payments should be paid only to the network level, to reflect the broad team of providers responsible for the savings. Providers' compensation cannot be tied in any way to savings achieved for their panel of consumers. This will avoid a very strong incentive to reduce care inappropriately.
- Rewarding improvements in quality, rather than meeting a single standard, gives every practice a reason to invest in care.
- Incentives should be tied to the level of quality improvement, removing an all-or-nothing, "cliff" effect that could encourage aggressive savings to reach it.
- No minimum savings rate should be required for networks to qualify for savings. This could create an overly-strong incentive to deny needed care and/or adverse selection.
- Providers and networks that improve quality should be rewarded. Quality is half of the value equation. That is, if costs stay the same but quality is improved, value has been increased, just as value is increased when costs are reduced and quality stays the same. There should be meaningful quality-based payments to networks that are independent of whether savings are achieved, with the money to reward for quality improvements absent shared savings coming from non-retained savings denied to providers, see below. This removes overly strong incentives to achieve savings that could result in underservice. Providers have more impact on the quality of care; total cost of care is extremely volatile. Reportedly Oregon devotes two thirds of all incentives to quality-only based network payments.
- When savings are denied to a network (non-retained) because they were generated by demonstrated underservice or cherry picking, those savings should be invested back into improvements in care, and to reward other provider networks which do well on quality even when money is not saved (in recognition of the enhanced value achieved). In no event should networks have an opportunity to recover those savings payments, regardless of meeting conditions developed by Connecticut's Department of Social Services (DSS) or any other body. The savings must be directed to an independent quality entity and cannot displace current spending by the network. They should also be used to reward provider networks which do well on quality without saving money. Savings

generated at the expense of needed care should be returned to the original purpose – to build value.

- The consequences of a finding of underservice or adverse selection should be:
 - First, a right of appeal to ensure that the finding is accurate. An independent quality organization should investigate to identify the source/cause of the problem.
 - Next, a constructive Corrective Action Plan (CAP) should be drafted. The CAP should be meant to improve performance, not to punish providers. This should be viewed as helpful assistance to providers and serve as an incentive to participate in Medicaid, rather than an added burden. DSS should use Medicaid's PCMH glide path assistance as a model. The CAP should be drafted and monitored by an independent entity, in collaboration with network providers.
 - The independent organization should provide technical assistance to the network to implement the CAP, but no direct funds.
 - CAP spending cannot displace current network spending.
 - CAP implementation assistance can be funded through non-retained savings, when possible, but, in the absence of savings, the state should invest in improving care delivered to every Medicaid member.
 - If concerns continue and no progress is made, the entire network must be removed from shared savings eligibility. The state should also consider their removal from the Medicaid program.
- It must be clear to all networks and providers that they will never get a chance to access non-retained savings. They must work to improve quality and earn next year's savings payments.
- Networks and providers found to have denied care due to underservice, adverse selection or not meeting quality standards should receive enhanced scrutiny in future monitoring.
- Risk adjustment methodologies must include social and demographic factors to ensure that resources are sufficient to improve health. Until the science of risk adjustment catches up, the state should include separate payments for people with complex health needs.
- Rates should be adjusted for unpredicted systemic costs – i.e. flu season, new drugs
- The state should use available methods, including cost truncation, risk corridors and reinsurance, to ensure that unanticipated, non-preventable costs of care for people with high levels of need do not erase more modest savings on the larger population achieved through better health.
- Even though the state is only considering one-sided or upside-only risk arrangements at this time, the state needs to monitor for de facto downside risk and its impact on incentives to achieve savings inappropriately. De facto downside risk occurs when providers lose money, such as due to initial investments or low Medicaid payment rates, in the foundational fee-for-service system. This

creates a strong incentive to cover those losses with shared savings payments. This monitoring should especially focus on provider groups new to Medicaid.

- The state should consider making advanced payments to networks for start up costs, either grants or very flexible loan repayment terms. This will help avoid de facto downside risk, in which networks have to achieve savings payments to recover their investment.
- Any care coordination payments to networks should continue during the life of the grant and should not be reduced on the theory that they can “make it up in shared savings,” as this would both discourage the necessary investment in care coordination and provide an incentive for under-service due to de facto downside risk.

Network requirements

- Requirements for all advanced networks and FQHCs participating in shared savings must be the same. Consumers deserve the same level of care and protections regardless of where they seek care.
- As with any state plan benefit under this authority, networks must include comparable services for all Medicaid populations and allow for any provider that meets defined qualifications to participate.
- States also need to ensure that the attribution relationship does not inhibit free choice within any Medicaid service. For instance, a primary care physician who serves as a primary care medical or health home cannot restrict the beneficiary’s ability to make an appointment with any other physician who is qualified and willing to provide care.
- Networks must include 75 percent of Medicaid primary care practitioners and at least four behavioral health providers in the defined geographic area.
- All primary care practices participating in shared savings must have achieved the highest level of national recognition as patient-centered medical homes.
- Consumers must have a diverse set of options for care managers to choose from.
- Robust access standards for care must be developed, monitored and enforced with meaningful penalties. This must include relevant categories of both primary and specialty care providers taking new patients within a reasonable distance from each consumer.
- Consumers must be able to easily access out-of-network provider referrals from in-network providers, without resistance or bias, when that is their choice or need. In-network providers must cooperate and communicate as freely with out-of-network providers as in-network to ensure continuous care for every consumer.
- Each network must specify and document in their response to the RFP robust connections to medical and non-medical community providers and organizations to support consumers’ health. There must be multiple options for each service to

ensure consumer choice, and consumers need to be informed of all their options for available referrals without any preference, such as for corporate partners.

- Consumers should be informed of quality performance metrics, only from independent sources, to help inform those choices.
- Payments to community resources from the network should only reimburse organizations for minimal administrative costs, and those reimbursements cannot be based, or conditioned, on the network's receipt of shared savings.
- Each network must specify how they will track referrals to community resources to ensure consumer needs are being met, and how they will respond if they are not.
- Each network must specify in their response to the RFP specific connections, and documentation to support the existence and nature of the relationship, to include but not be limited to:
 - Housing, utility bill assistance
 - Nutrition, food assistance
 - Employment assistance
 - Education, child care
 - Transportation
 - Language and literacy training
 - Peer support services and networks
 - Criminal Justice system
 - Elder support services
 - Other state, local programs, medical and non-medical
 - Local health departments
- Networks must integrate both behavioral health and oral health providers as part of the care team, and describe in the application their plans for effective integration.
- Consumers with complex health needs must have a detailed care plan that is
 - Directed by, developed in collaboration with and approved by the consumer, and, when appropriate, their representative
 - Care plans should begin with patient goals, and all services and self-management targets must relate to those goals
 - Care plans must be specific about what services will be provided, the scope of those services, who will provide them, and the expected outcome
 - Care plans must be updated for major transitions in care or every year, whichever is earlier
 - Care plans must be available to every provider and care manager caring for the patient, as well as to the patient and anyone else they designate
 - Networks must describe in their response to the RFP how they will identify people with complex health needs including referral sources and qualifying parameters

- The state should monitor and track care plans for people with complex health needs, analyzing for patterns and concerns, including underservice or inappropriate overtreatment.
- MQISSP should explore how to responsibly certify, utilize, and pay for new workforce options such as community health workers
- Networks must outline how they will develop, disseminate and evaluate individualized, appropriate self-management tools for consumers.

Quality

- DSS must conduct robust monitoring for underservice and adverse selection annually to include at least:
 - Comparison of underservice between networks and non-MQISSP populations
 - Comparison between practices in the same network
 - Tracking risk scores and diagnoses of people leaving networks
 - Identify at-risk populations, and study these directly
 - Claims analysis is just a first cut. Analysis must drill down for more information including causes, and mechanisms, of underservice.
 - Comparisons between populations with different coverage sources within each network
- All quality reporting, in full detail, must be publicly available. DSS must also create consumer-friendly quality comparison tools to help consumers making decisions about their care.
- All quality, underservice and adverse selection monitoring must be performed by independent External Quality Review Organization entities, free of shared interests with any state agency, network, provider or insurer in Connecticut, as required in CMS's new proposed Medicaid managed care regulations. It is preferable to use more than one contractor for this work, to ensure robust monitoring and efficiency, and to foster innovation.
- Balance quality performance standards between rewarding high performance levels with rewarding individual improvement over time. It is critical to both ensure that high performers are rewarded and also to raise the quality of care provided by lower performers. Every Medicaid consumer deserves the best possible care.
- Each network must develop a public Quality Improvement Plan, with a clear methodology and information sources to identify needs, specific solutions and clear responsibilities, with timelines, identified resources and a robust evaluation to assess progress.
- It is important to ensure that quality metrics are driving improvement by including both moderate goals and some that are a stretch.
- The breadth of quality standards to qualify for savings must be sufficient to ensure a reasonable baseline of quality care. Shared savings is different from

pay-for-performance and PCMH quality incentive programs that include no financial risk, and so it requires far more extensive quality (and under-service) standards to protect consumers and taxpayers.

- The state should retire quality standards over time as networks improve, replacing them with new goals based on population needs.
- In collaboration with consumer advocates, DSS must develop a robust underservice-monitoring plan. The process used for developing the health neighborhood underservice-monitoring plan serves as a good model for an inclusive, comprehensive process, but that will list will not suffice as the new proposed shared savings program will apply to a different population.
- As no underservice-monitoring plan will be perfect, it is critical not to share details of underservice monitoring with networks as it is being conducted. Underservice monitoring should serve as a safety net, not a roadmap to gaps in monitoring.
- The state must evaluate MQISSP underservice monitoring regularly to improve identification and keep up with the quickly evolving health care marketplace.
- There must be full public reporting of any findings of underservice or adverse selection, including notification of all consumers in the affected network.
- Underservice, adverse selection and quality must be measured at the network, practice and provider level. While defining a statistically valid population for measurement may be challenging at a granular level, a great deal of harm could be missed if only large populations are chosen for measurement. In addition, the system must be designed to detect individual examples of unambiguous and egregious inappropriate care – some things shouldn't happen even once.
- Quality, underservice and adverse selection monitoring should over-sample at-risk populations and providers with a history of under-performance.
- Networks should be penalized even if only one provider or practice is found to be systematically underserving, cherry picking or consistently not meeting quality standards. As savings are shared, so should responsibility for quality care.

Questions for networks in the RFP:

- How will you make this work with current Medicaid rates?
- How will you manage with losses or no savings, even in upside-only risk?
- Explain plans to care for or arrange care for those who opt-out *and* excluded populations
- How will you segregate Medicaid members' needs, rights, and funding from that of other insurers?
- How will you actively monitor for under-service by providers in your network incentivized by shared savings?
- How will you actively support and protect PCMHs already operating in Connecticut's Medicaid program?
- How will you ensure effective outreach to improve care for high-need, high-cost consumers?