Medicaid Study Group's Comments on MQISSP Planning and Draft Concept Paper to CMS

December 17, 2015

The Medicaid Study Group wishes to thank Connecticut's Department of Social Services (DSS) and the legislative Medical Assistance Program Oversight Council (MAPOC) for the extraordinary level of engagement with consumer advocates and all stakeholders in development of the Medicaid Quality Improvement and Shared Savings Program (MQISSP). We hope this becomes customary practice across other areas of health policy-making in our state.

We also want to thank DSS, as the final decision maker in MQISSP development, for adopting many of the Medicaid Study Group's recommendations. We especially applaud the adoption of shared savings methodologies such as not setting a Minimum Savings Rate, using both absolute and quality improvement factors, avoiding downside risk, and adopting multiple incentives and opportunities to improve quality. We especially appreciate the hybrid savings pool that re-invests non-retained savings back into the original goal of improved quality, and consequently the value, of care even if total dollars are not immediately saved. We expect that these innovative strategies will serve as best practices for states just beginning to consider Medicaid payment reforms.

We also want to thank DSS for its wise decision to attribute members to MQISSP only to the extent that they are receiving care from already (nationally) accredited Patient-Centered Medical Home (PCMH) practices. This honors the Guiding Principle, strongly endorsed by MAPOC's Care Management Committee, to build on our state's successful PCMH program that has delivered extraordinary improvements in quality, access to care and cost control. It also is the best means to minimize harm to what is working in our current Medicaid program and avoid undermining that successful model. MQISSP qualification could also serve as a further incentive, in addition to current higher reimbursements, to practices that have not yet transformed their care delivery to move to PCMH, improving care for even more Medicaid members.

The Medicaid Study Group has formed to advise Connecticut's DSS and MAPOC's Care Management Committee on the development of MQISSP, particularly on protective steps to preserve and grow our successful PCMH program and to ensure that any reform of health care delivery is done in a manner consistent with the best interests of Medicaid enrollees. It formed after DSS asked that advocates more generally use the Care Management Committee as the means for collecting comments to the agency about MQISSP model design. The Group consists of more than twenty independent consumer advocates who have taken a deep dive into the literature and the experience of similar programs in other states. The Group developed a set of recommendations for MQISSP development and is reviewing

proposals as they are developed by DSS. This letter is part of that feedback. We look forward to continued discussion and collaboration.

Comments on current MQISSP proposals:

PCMH requirements for MQISSP participating entity (entity)

- Require **all** primary care practices in entities (Federally Qualified Health Centers and Advanced Networks) to be certified by a nationally recognized body as PCMHs, in order to participate in MQISSP.
- If that is not possible, then, at a minimum:
    - Require entities to reach 100% certified PCMHs within 12 to 18 months of the contract start date.

    And
    - Monitor such mixed entities for internal "cherry-picking," meaning attributing patients that are likely to generate savings into PCMHs and moving patients less likely to generate savings out of PCMHs.
    - Heighten monitoring of entities that generate the most savings.

    And
    - If within 12 or 18 months, an entity has either not reached 100% PCMHs and/or has cherry-picked patients as described above, their contract will be void and they will not be eligible to receive any shared savings that would otherwise be provided. They can re-apply to MQISSP when they have achieved 100% PCMH status.

Communications

- Develop a two-way communications plan that both informs and solicits meaningful feedback from consumers – before, during, and after program implementation.
- Ensure all communications are balanced and neutral with regard to both potential benefits and risks of shared savings.
    - DSS must approve all entity member communications, as was the case for the HUSKY Managed Care Organization contracts, whether it is identified as coming from DSS or the entity.
- Communications must be written at or below a seventh grade reading level.
- Communications must be clear about financial incentives in the shared savings model, the potential impact of those incentives on treatment decisions and provider recommendations, and what people can do to protect themselves.
- Evaluate the effectiveness and availability of communications in consumer surveys, including awareness of the choice and means to opt-out.

Entity oversight requirements

- The proposals for oversight bodies at each entity are very good and incorporate many of the Medicaid Study Group's recommendations. But

building on consumer advisory committees in Connecticut and other states, we have some suggestions for improvement.

- To ensure consumer input is meaningful and diverse, require 51% or more of members to be independent MQISSP consumers attributed to the entity or independent advocates for MQISSP members.
    - To ensure that consumer qualifications are not so narrow that they become a barrier to robust consumer representation, add desirable categories of membership as preferences rather than requirements.
- A strong conflict of interest requirement for consumer/advocate members of the oversight body is critical to ensuring independence and honest, constructive input crucial to success in this very new, untested model of care delivery and payment.
- To ensure oversight body meetings are productive, schedule them at least quarterly on a regular, pre-determined calendar, but entities must have a process to call interim meetings when needed to keep agendas manageable and decisions timely.
- To ensure meeting arrangements accommodate consumer member needs, require at least 75% of all consumer/advocate members must be in attendance for each meeting.
- Allow consumer/advocate members to designate proxies if they cannot attend, so their voice is not lost.
- All substantive policy decisions should be reviewed in advance by the consumer-focused oversight body, including entity financial performance, policies and shared savings distribution.
- Transparency of oversight bodies' work is critical to success. Membership lists must be public, as well as all meetings, minutes and agendas, allowing for redaction of proprietary information.
- In the event that an oversight body is different from an entity's governing body, all recommendations of the oversight body shall be shared, in writing, with the governing body, which shall respond in writing. All recommendations and responses should be sent to DSS and MAPOC's Care Management Committee.
- Consumer members should be offered transportation, childcare and other necessary support to attend meetings.

Community Care Team integration

- Add local Community Care Teams (CCTs) to the list of required community partners for entities.
- Require that CCTs share in shared savings payments by agreement with the entity.

Governance

- Insurers or managed care organizations, including any subsidiaries, shall have no role in participating entity ownership, governance or decision-making.
- To ensure effective connection between the oversight and governing bodies, at least two consumer/advocate members of an entity's oversight body must also serve as voting members of the governing body.
- Entities must be subject to state Freedom of Information laws for their MQISSP business, and the contracts with the entities must so state.

Shared savings- calculation and distribution

- It is critical that shared savings calculations and methodology are sound. Savings payments and program performance must reflect true savings and improved value rather than an artifact of risk segmentation.
    - We are concerned that already higher-performing practices are most likely to participate in the early phase of MQISSP, resulting in a false finding of savings and quality improvement in the program relative to lower performing practices outside the program. This could be misunderstood as evidence of success in achieving higher value for the first wave of MQISSP when, in fact, nothing has changed. This could also result in the state granting savings payments to providers that are now being captured by the state.
- It is critical to be able to compare MQISSP practices to a valid control group, and to have a benchmark of historic trends comparing MQISSP to non-MQISSP practices.
- Higher reimbursement levels between different categories of provider, i.e. FQHC vs. community providers and differing hospital rates, must be accounted for in shared savings calculations.
- Individual providers' compensation cannot be based, in any part, on savings generated on their own patient panel, and this must be a clear commitment in the RFP. This follows the recommendation of the SIM Equity and Access Committee that, without this protection, there is too strong an incentive for a provider to save money on his or her own patients which could drive inappropriate underservice.

The role of SIM's Community and Clinical Integration Program (CCIP)

- Participation in CCIP must be voluntary for all MQISSP entities.
- Entities should be able to choose which CCIP services they need, and which are better provided by the entity or by other community or clinical resources.

Entity procurement

- Standards and guiding principles, such as building on and supporting the current, successful PCMH program, must not be compromised in any way. The RFP must ask how the networks will affirmatively support and advance

this program and applicants with inadequate responses to this must be rejected. (Reported requirements set outside MAPOC's Care Management Committee that at least two advanced networks will necessarily be included in the program have already eroded PCMH standards for MQISSP.)
- Rules and requirements must be equivalent between FQHCs and advanced networks to avoid different levels of care and consumer protections.

Additions to the Draft Concept Paper to be submitted to the Centers for Medicare and Medicaid Services:

- Add language that underservice monitoring and protections will be developed and that entities found to have systematically underserved or cherry-picked (in or outside of an FQHC or advanced network) patients will not receive shared savings, whether or not such under-service or cherry picking is intentional.
- Add language clarifying, for entities that do not have 100% nationally-accredited PCMHs at the inception of the program, the state will develop monitoring plans and require them to reach 100% in their DSS contracts, with termination of the contract and denial of any shared savings if this is not accomplished within 12 to 18 months.
- Add language that individual providers' compensation cannot be based, in any part, on savings generated on their own patient panel.