Connecticut Health Policy Project

March 8, 2016

Commissioner Roderick Bremby
Department of Social Services
55 Farmington Avenue
Hartford, CT 06106

Re: Need for Enforceable Requirement of Full PCMH Participation by Primary Care Practices in MQISSP Advance Networks

Dear Commissioner Bremby:

We are writing to urge your agency to protect and support Person-Centered Medical Homes in developing the Medicaid Quality Improvement and Shared Savings Plan (MQISSP). MQISSP was precipitated by the State Innovation Model (SIM) grant requirements and has been developed under a protocol negotiated between your agency and SIM. As consumer representative members of the Care Management Committee of the Medical Assistance Program Oversight Council, tasked with advising your department in the development of MQISSP, we note that this has been a very active area of discussion in our meetings with deep concerns voiced by many members- not just consumer members.

Person-Centered Medical Homes (PCMHs) are the foundation of Medicaid reforms that have made substantial improvements in access to high-quality care for the people who rely on the program, while significantly lowering costs for the state. All stakeholders, including your agency in particular, have strongly committed to ensuring we do no harm to PCMHs in the development of MQISSP. Unfortunately, we are concerned that current proposals for PMCH requirements of MQISSP provider networks, both Advanced Networks and Federally Qualified Health Centers, will move the program backward, potentially deny PCMH care to the members who need it most, and **increase** costs to the state.

We strongly support a requirement that **every** primary care practice participating in MQISSP Advanced Networks be certified as a PCMH to support those practices that have transformed to patient-centered care and encourage others to do so as well. Your department has rejected this provision stating that it is their belief that there are not two Advanced Networks in the state that can meet this standard currently. We also understand that a promise was made to SIM by some in the administration that at least two Advanced Networks would be included in MQISSP.

We fully support the department's decision to include in the shared savings program only members attributed to PCMH primary care practices. However,

allowing non-PCMH practices in MQISSP networks creates some highly problematic incentives. Networks will have an incentive to move members on whose care they can save money into PCMHs, which can participate in shared savings, and people who are not likely to generate savings **out** of PCMHs. There are several problems with this arrangement, including moving exactly the people who can most benefit from PCMHs out of them and vice versa, as well as generating false "savings" by segmenting risk. This proposal also gives networks an incentive to halt, and possibly reverse, the momentum Medicaid has enjoyed of rising numbers of PCMH practices in the program. Networks will have a direct incentive to retain a sufficient number of non-PCMH practices to provide a place for less lucrative members, who are "off the books" in the shared savings calculation.

We urge you to require all primary care practices in networks to be PCMHs as a condition of MQISSP participation. It is our understanding that all Federally Qualified Health Centers are now certified or soon will be. We are also aware of at least one advanced network in the state that also meets this criterion. And for those networks which are not yet at the 100% participation level, they will still be able to fully participate as Medicaid providers, including participation in the financial incentives and rewards under the existing, highly successful PCMH program for their practices which have received recognition or are on the glidepath to doing so, i.e., there is no danger from such a requirement of encouraging networks and practices now participating in Medicaid to cease to be Medicaid providers.

However, in the absence of this important consumer and taxpayer protection, we urge that, at a minimum, Medicaid require that all primary care practices in MQISSP networks be PCMH-certified within 18 months of the program's start date. Furthermore, there must be clear and meaningful financial consequences for non-compliance with this provision, to prevent foot-dragging so as to take advantage of a non-PCMH setting for less lucrative enrollees. If all PCMHs are not certified within that generous timeframe, the entire network should forfeit 75% of any shared savings earned until they are compliant.

We understand that on occasion, despite every effort, a practice in a network may not attain accreditation within this generous timeline. We can agree to a time-limited, good faith waiver, at the discretion of the department and CHNCT, for a limited number of practices that are demonstrated by CHNCT to be making a sincere effort and expect to achieve certification soon. But in the absence of a significant financial penalty for failing to meet this requirement (or coming close to meeting it through good faith efforts), the incentives will otherwise invite the networks to maintain non-PCMHs, keep the enrollees who most need them out of PCMHs, and threaten the great success that the Department has seen in its PCMH program, potentially costing the taxpayers dearly.

These requirements must be clearly stated in both the MQISSP Request for Proposals due out this summer and in the eventual contracts with networks. It is critical that networks are clear that moving patients now or in the future to improve financial gains will not be tolerated or effective.

We remain committed to working with your department to continue and build on the remarkable success our state's Medicaid program has earned.

Respectfully yours,

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