

Via email: sim@ct.gov

November 30, 2013

Victoria Veltri
Healthcare Advocate
Office of the Health Care Advocate
Hartford, CT

Re: Comments to Proposed State Innovation Model Plan Draft V1.1

Dear Ms. Veltri:

I submit the following comments on behalf of Connecticut Voices for Children, a research-based think tank that advocates for policies that benefit the state's children and families, including policies that increase access to quality and affordable health coverage and care to low-income children, pregnant women, and families. The perspective of Connecticut Voices staff is informed by years of experience monitoring enrollment and health services utilization in the HUSKY program¹, coordinating the Covering Connecticut's Kids & Families Coalition², and participating as appointed members on the Council on Medical Assistance Program Oversight, the Connecticut Behavioral Health Partnership Oversight Council, the Consumer Advisory Board, and All-Payer Claims Database (APCD) Advisory Group.

First, we applaud the effort that has gone into developing this comprehensive plan to markedly change the overall health care delivery system of our state in order to improve access, quality of care, reduce health disparities, "promote value over volume" of services and reduce unnecessary costs.

Our comments focus on two areas: 1) quality metrics and 2) the implications of the payment reform model on the HUSKY program.

Quality Metrics

¹ Since 1995, independent performance monitoring has been conducted under a contract between the Connecticut Department of Social Services and the Hartford Foundation for Public Giving (Contract #064HFP-HUO-03/10DSS1001ME-A1). Under a grant from the Hartford Foundation, Connecticut Voices for Children conducts the HUSKY performance monitoring described in this state-funded contract. Annual reports on enrollment, preventive care (well-child and dental), emergency care and births to mothers with HUSKY coverage or Medicaid can be found at www.ctvoices.org.

² Connecticut Voices for Children is the lead agency for the Covering Connecticut's Kids and Families (CCKF) initiative, a statewide coalition of state agencies and organizations concerned with access to health care for children and their parents. Currently, CT Voices coordinates statewide meetings of the CCKF member organizations where information about HUSKY Health and related health care issues is shared. These meetings are open to all organizations interested in HUSKY enrollment and access issues. CT Voices also manages an e-mail listserv to help the Coalition and other interested persons or groups keep abreast of health care issues affecting families and children.

We have questions about what metrics will be used to determine whether children and adults are receiving the right kind of care in the right setting at the right time. We recognize that some criteria are easier to quantify than others. For example, the increase or decrease in the number of visits to the emergency department for ambulatory sensitive conditions (conditions, such as asthma, that could have been treated at a doctor's office or with patient access to a help-line) may well be an appropriate metric. It is relatively easy to define and measure.

There is little in the 154 page document, however, that sets forth how such metrics will be determined, by whom, and at what stage of implementation.

Also, how will access to dental and behavioral health services be integrated in to the model and included in the quality metrics?

It is critical that all providers and plans collect racial and ethnic, and primary language, as well as other demographic data in order to know whether and to what extent we are serving minority and poor populations and reducing health care disparities among these at-risk groups, thereby increasing health equity. In short, how will this information be collected and standardized?

As an organization that has analyzed gaps in insurance coverage for children and pregnant women in the HUSKY program, we know from the literature and our own work that gaps in coverage lead to loss of access to care, and increased administrative costs to reenroll eligible individuals.³ Continuous coverage is a predicate for measuring quality of care over time. How does SIM help improve continuous coverage, particularly for our most vulnerable children and families?

How will we know that we are getting better value for the money? How will we know that we have integrated behavioral, physical, **and** dental health into the health care delivery system? In particular, how will dental care be fully integrated into the model? Will primary care providers screen for dental health issues?

We also recommend that there be explicit references to the potential linkage between the development of the "All Payers Claims Database", and the Plan. We see the APCD as being a mechanism that will allow the state to access utilization and claims data across payers. How will the APCD be integrated into the SIM?

How will other important and ongoing initiatives be integrated into the Plan, e.g., Person-Centered Medical Home (PCMH) and Health Information Exchange (HIE) to support continuous program improvement and assist in reducing racial and ethnic disparities in our health care system and improve overall health of the covered populations?

Payment Reform and HUSKY

Connecticut can be proud of the initiatives that it has taken to improve access to quality care in its HUSKY (Medicaid and CHIP) program. The Dental Health Partnership (CTDHP) combined increased payments to dental providers (in particular for pediatric services) with a non-risk administrative services organization that manages the provider network, engages in utilization reviews, and provides help to consumers with finding a dental provider and scheduling appointments.⁴ So too the CTBHP has increased access to community

³ See for example, Lee, MA., Children in the HUSKY Program Experience Gaps in Coverage: An Update, Connecticut Voices for Children (May 2012), available at <http://www.ctvoices.org/sites/default/files/h12huskycoveragegaps.pdf>.

⁴ Lee MA., Feder K., Learned A., Dental Services for Children and Families in the HUSKY Program: Utilization Continues to Increase Since Program Improvements in 2008, Connecticut Voices for Children (July 2013) available at <http://www.ctvoices.org/sites/default/files/h13dentalcare11useincreasesfull.pdf>

based behavioral health and substance abuse services for the HUSKY population through a non-risk ASO model.⁵

Medicaid currently serves over 600,000 low-income children, parents, pregnant women, individuals with severe disabilities, and seniors. The Affordable Care Act (ACA) recognized that in many states, including Connecticut, providers receive payments that are far lower than those paid by private health plans and/or Medicare. The ACA provides for increased payments to Medicaid primary care providers for 2013 and 2014 in recognition of the fact that many more people will be accessing the program starting in 2014 due to the insurance mandate and the expansion of Medicaid to more low-income residents. It is not known whether or to what extent the federal and/or the state government will continue the higher reimbursement rate for primary care providers beyond 2014. In Connecticut, it is no secret that patients can have an especially difficult time finding specialty care, such as orthopedists and dermatologists, in large measure because of low Medicaid reimbursement rates.⁶ The ACA does not require that specialty care rates in Medicaid be increased.

We are therefore very concerned about any “shared savings” or payment reform measures that would have the unintended consequence of reducing access to Medicaid providers. Health care providers are not required to participate in the Medicaid program and many do not, especially specialty providers. The SIM should incentive *all* providers to serve Medicaid patients. Perhaps it is time for the state to consider requiring providers to accept Medicaid as a condition of licensure. This could take the pressure off our “safety net” health care providers, and increase access to primary and specialty care – particularly in our rural areas and or other locales where federally qualified health centers are less available.

Thank you for this opportunity to comment on the Plan. Please feel free to contact me or my colleague Mary Alice Lee, Ph.D. if we can be of assistance in the development of the SIM initiative.

Very truly yours,



Sharon D. Langer, M.Ed., J.D.
Senior Policy Fellow

⁵ See, reports to the CTBHP Oversight Council at <http://www.cga.ct.gov/ph/BHPOC/>

⁶ Hero, J., Lee, MA., Medicaid Provider Reimbursement: Recent Changes to Pediatric, Obstetric and Other Selected Fees, Connecticut Voices for Children (April 2008), available at <http://www.ctvoices.org/sites/default/files/h08medreimbursefees.pdf>. In 2007, Connecticut lawmakers increased reimbursement rates to Medicaid providers. Medicaid fees improved in comparison to Medicare fees for Connecticut. Overall, pediatric rates in 2008 rose to 85% of Medicare rates, up from 82% in 2006. However, fees for office visits for adults and pediatric specialty care were only at 57% of Medicare rates in 2008, up from 45% on average.