

June 23, 2014

Commissioner Roderick Bremby
Department of Social Services
25 Sigourney Street, 12th Floor
Hartford, CT 06106

Re: Comments to Revised Medicaid PCMH Draft Regulations

Dear Commissioner Bremby:

We write as both consumer advocates who are members of the Care Management Committee of the Council on Medical Assistance Program Oversight and other concerned advocates, to respond to the substantially revised draft of the Medicaid Patient-Centered Medical Homes (PCMH) regulations which was presented to the Care Management Committee by DSS representatives at its last meeting on May 21, 2014.

First, we wish to express our appreciation that many of the changes recommended by consumer advocates to the prior draft, circulated in 2012, have been made.

Second, the department's March 24, 2014 document entitled "Response to Comments on Regulation 11-14" did not mention that the department was substantially revising the draft in a manner that was not addressed in any of the comments, namely, by authorizing the department to reject the long-standing and effective National Council on Quality Assurance (NCQA) PMCH certification standards for the department's Connecticut-specific "standard-setting authority for PCMH status." Proposed Section 17b-262-927(34). Under the last section of this document entitled "Summary of the Department's Other Revisions," the department made only a vague reference to "clarify[ing] PCMH status requirements", which was not an adequate notification or summary of the proposed wholesale replacement of the NCQA standards, as in fact is contained in the revised draft. Given this, the department should consider these comments to its proposed revised draft to be entirely timely.

Third, in light of this major revision in the draft regulations without adequate notice, we believe that the Department should reissue the draft with a specific invitation for comment about the proposal to replace NCQA PCMH standards with local department-specific standards.

Fourth, the proposal to allow DSS to abandon the highly successful NCQA standards in favor of a not-yet-developed home grown experimental standardⁱ is deeply troubling for many reasons, as set forth below.

1. The NCQA standards are successfully engaging primary care providers in the Medicaid program

- As of 5/8/14 there were 249,224 Connecticut Medicaid members being served by 1,193 PCMH providers to which the NCQA standards are being applied. Those numbers grow every month. CHN reports that virtually all practices that enter the Medicaid NCQA

glide path and make a commitment to practice transformation are successful in achieving PCMH recognition

- CHN has reported **no complaints** by providers about the PCMH standards being too difficult or not worth the effort
 - CHN reports that virtually all primary care providers who enter the glide path to NCQA certification ultimately obtain that certification
 - The only complaints reported concern the one-time costs and time commitments to achieving transformation, which is something that we should want from our quality Medicaid providers. The limited burdens can be addressed by support provided, as we successfully have done under the Medicaid glide path program.

2. With NCQA standards in place, care is improving for Medicaid enrollees

A basic tenet of effective policy-making is not to fix what is not broken. The nationally recognized NCQA patient centered medical home standards are a very effective tool, which have been perfected over time, are widely accepted and have demonstrated success in improving the quality of care, as seen in Connecticut's Medicaid program. The adoption of the NCQA standards in Connecticut's Medicaid program has significantly improved the quality and value of care in the program. Care delivered in PCMH practices exceeds the quality of care delivered by non-PCMH practices:

- Children being seen in PCMH practices are over 10% more likely to receive recommended EPSDT screenings.
- Quality metrics in PCMHs are better than non-PCMH practices for
 - Adolescent well-care visits
 - Well child visits < 16 months age
 - Well child visits 3,4,5, and 6 year olds
 - Adult access to primary care
 - Annual dental visits
 - Eye exams for people with diabetes
 - LDL screens for people with diabetes

3. The NCQA standards contain critical consumer protections which should be codified by the regulation

There are very good reasons for the strong PMCH standards developed by NCQA , including important consumer protections. For example, they include the requirements of "Patient-Centered Appointment Access" (same-day doctor visits for urgent care needs) and "Referral Tracking and Follow-Up." These are important tools for keeping people out of the Emergency Room, resulting in improved access and quality while controlling costs responsibly. There are many other NCQA standards which also protect consumers and which should not be watered down.

4. NCQA has become the predominant PCMH recognition standard, Connecticut is already broadly using it, and it is regularly updated. There is no reason for Connecticut Medicaid to move away from it.

- Four out of five PCMHs in the United States are recognized by NCQA, allowing apples-to-apples comparisons with other states, and allowing Connecticut to benefit from lessons learned elsewhere
- There are 1,047 NCQA recognized PCMH practices and providers in Connecticut as of May 25, 2014, and the list grows every month, so it clearly is not an unreasonable standard for providers to reach
- NCQA standards also evolve with the changing health care landscape, updating every three years to accommodate best practices and lessons from the growing PCMH literature
- NCQA has made multiple changes to significantly reduce the administrative burden on providers – the goal is to make recognition a byproduct of practice transformation
- CT now benefits from NCQA’s significant investment, expertise and knowledge of PCMH best practices

5. The one concern with NCQA certification -- that it occurs only once every three years -- has been fully addressed in Medicaid by CHN’s annual audits

Although there have been no complaints about the NCQA standards from providers considering certification to participate in the Medicaid PCMH program, a complaint voiced in other quarters is that the standards are applied only once every three years, at the time of certification or recertification. There is concern that a practice might not be living up to those standards in the interim. However, DSS and CHN have fully addressed this concern by developing an innovative review program called Quality Assurance Annual Reviews (QAARs) to ensure that the practices which received this certification are indeed living up to it. With this innovation, this one complaint with the NCQA standards has been fully addressed.

Perhaps the best answer to this concern, apart from the ready solution of regular audits, is that the current system is **working**. As described earlier, there is a substantial difference in the quality of care and patient experience of care in Connecticut Medicaid PCMH practices compared to non-PCMH practices. The current system for certification and monitoring is working to reward value, which is the eventual goal for health care reforms.

6. The fact that not **all** Medicaid-participating primary care providers have signed up under the NCQA standards is not a drawback to NCQA standards,

The fact that not all Medicaid-participating primary care providers have signed up to obtain PCMH certification under the NCQA standards has been cited as justification for developing Connecticut-specific standards, even in the absence of any complaints with those standards themselves. However, it was never expected that **100%** of primary care providers would pursue or achieve PCMH recognition under the NCQA standards or glide path. This cannot be expected under any national accrediting standards, no matter how well accepted, effective and supported they are.

- The investment may not make sense for some practices
 - They will still receive payment for the health services they provide
 - With an expected primary care shortage, non-PCMH practices will not have trouble filling their panels
 - 100% should not be the goal or justify lowering standards.
7. There is no justification for Connecticut spending taxpayer money to reinvent the wheel when NCQA has already expended millions of dollars to develop nationally recognized standards which are working everywhere, including in Connecticut's Medicaid program

The authorization which the draft regulations would give to CT Medicaid could cost a large sum of money, just to reinvent the wheel. NCQA has spent \$10 million in this effort. It is not credible that Connecticut could develop its own home grown standards which would be as effective, at least in the absence of an enormous expenditure of precious taxpayer funds which could otherwise be spent on providing and improving access to health care. And if the state developed its own standards inexpensively, our Medicaid program would likely get exactly what it paid for, ultimately at the expense of Medicaid patients and the taxpayers.

8. Connecticut-specific PCMH standards would be subject to erosion by future political changes in administration

Assuming, as we do, that any home-grown PCMH standard developed by the current Department of Social Services for the Connecticut Medicaid program would be well-intentioned, the new regulatory language would place the program at potential risk if another, future administration used the vague language to weaken the standards, including just to save money. As an independent, national, non-profit organization only responding to research and best practices, NCQA and their standards are immune to changes in Connecticut's political environment. Since, under neither the current administration nor such a future administration, nothing is to be gained by Medicaid enrollees or providers from a home-grown PMCH standard, there is no justification for authorizing it in these proposed PCMH regulations.

For all of these reasons, the attempted wholesale rewriting of the draft PCMH regulations so as to allow DSS to develop lower Connecticut Medicaid-specific PCMH certification standards in place of effective, proven, carefully developed national standards is unwarranted and should be removed in the revised draft of the regulations. At most, the regulations should define a "PCMH status standard-setting authority" as set forth in proposed Section 17b-262-927(34), including reference generally to one or more **national** "recognized PCMH standard-setting organizations selected by the department as an authority whose standards apply to practices seeking or maintaining PCMH status, such as the National Committee for Quality Assurance (NCQA)," but deleting the reference to "or the department as a standard-setting authority for PCMH status." Doing this allows for the possibility that, some time in the future, a national body **other** than NCQA may take over as the predominant, effective PCMH standard, while removing an inappropriate authorization for DSS to waste taxpayer dollars attempting to reinvent the wheel.

Thank you for your attention to our recommendations as consumer advocates concerned about preserving the substantial success of nationally-accredited PCMHs in the state's Medicaid program.

Respectfully yours,

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ⁱ The home grown standard potentially may be weaker. *See* State of Connecticut, SIM Design Model Care Delivery Workgroup, Meeting Minutes, June 24 and July 8, 2013.