

**LAST MINUTE MAJOR CHANGES TO SIM PLAN CONCERNING MEDICAID
SHOULD BE DISAPPROVED**

The final SIM plan submitted to CMS in December, 2013 was clear that there would be a go-slow approach to putting Medicaid enrollees into risky shared savings arrangements. In that document and in many public meetings, DSS committed that:

“With respect to payment reform, the Department’s original position was that we would inaugurate our use of shared savings with the CMS Demonstration to Improve Care for Medicare-Medicaid Enrollees [“duals demo”]. The Department further committed in the SIM State Health Innovation Plan to align with other payers to the extent of implementing an upside only shared savings program for the general Medicaid population. In support of this, the Department proposed to review the early experience of other payers with this approach, to assess the need for protections for Medicaid beneficiaries and on that basis to determine when during the test grant period to implement an upside only shared savings program.” July 1, 2014 DSS Document, page 3 (emphasis added).

DSS necessarily committed, in order to ensure “protections for Medicaid beneficiaries,” that shared savings would roll out under “other payers” first, and later Medicaid enrollees other than duals would be assessed for possible inclusion. DSS repeatedly assured the public that Medicaid would not lead the market in shared risk and, on that basis, consumer advocates did not express opposition to the final December plan.

But just days ago, with the SIM grant application due in two weeks, this commitment has been abandoned, driven by the SIM planners who have belatedly stated: “Early [Medicaid] participation within the grant period is warranted in support of achieving CMS identified goals related to a federal return on investment.” July 1st DSS document at page 3. SIM proponents are clear that the plan is changing at this late stage in an attempt to improve the chances of winning the federal grant.

SIM proponents propose two radical changes to the SIM plan and even to the Medicaid program, threatening harm to Medicaid enrollees:

- (1) Enrollment of at least 200,000 Medicaid enrollees in a shared savings plan by January 1, 2016, without sufficient planning, data and preparation, puts vulnerable Medicaid enrollees at high risk.**

Because the Medicaid shared savings plan, which incentivizes providers to save money on the total costs of their patients’ healthcare, will be rolled out without the careful planning that has gone into the duals demonstration, it will very likely cause harm to affected patients. Access to care for vulnerable Medicaid enrollees, already suffering from serious access issues, particularly with regard to specialists, could worsen because providers will have a direct financial interest in keeping the total cost of care down in order to achieve savings.

In contrast to these new, last-minute proposals, the Connecticut PCMH Medicaid program is improving care and saving money. Participating primary care providers receive payment for coordinating care and extra payments for doing well on agreed-upon quality measures, but do not have potentially harmful financial incentives to restrict access to care (or financial incentives to refer patients to other providers). Imposing broad-scale shared savings just 18

months from now, without the opportunity to assess its imposition on other populations, will fundamentally undermine, not “build on,” that success.

(2) Development of a Sec. 1115 waiver which will include a “global cap” or “budget neutrality” over a five year period on the federal share of Medicaid expenses returned to CT taxpayers, puts vulnerable Medicaid enrollees at high risk.

Under this proposal, the federal government would not be required to pay its full share of increased costs but only an amount to ensure budget neutrality, in order to obtain a small amount of flexibility to cover “air conditioners” and “community health workers”. Currently, Medicaid costs are shared between the state and the federal government based on the actual cost of services provided in the program, reimbursed between 50 and 100 cents on the dollar. But 1115 waivers require budget neutrality in terms of the federal government’s Medicaid payments to a state.

Some of the proposed “new” services to be obtained, like community health workers, are in fact coverable by Medicaid without a waiver, calling into question why this is even being proposed. In any event, the proposed resulting cap could result in increasing Connecticut’s Medicaid costs if, for example, health care costs continue to rise, unemployment grows or the state’s economy does not rebound, but our reimbursements are fixed.

Because these two proposed significant changes would be destructive to the Medicaid program and will not allow for careful development of protections before shared savings are widely applied to Medicaid enrollees, we urge MAPOC and the MAPOC Complex Care Committee to recommend that these proposed changes not be included in the Test Grant application and that the important commitments to CT’s vulnerable Medicaid enrollees, as contained in the December final plan, be followed in the final grant proposal submitted to CMS.