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PUBLIC COMMENT to the SIM Practice Transformation Taskforce
June 24, 2014

Re: National Standards for Patient-Centered Medical Homes in CT

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Executive Director

Thank you for the opportunity to share our opposition to SIM's decision last year to reject national standards and develop Connecticut-specific standards for patient-centered medical homes (PCMHs). We at the CT Health Policy Project are dedicated to improving access to health care for every Connecticut resident. No one is more committed to constructive health reform than consumer advocates. Independent consumer advocates have offered constructive, feasible options to improve the SIM plan almost from its inception.

We hear every day from callers on our helpline and others about the difficulty accessing needed care in our state's increasingly fragmented, stressed and expensive health system. The best available tool to address these problems has been PCMHs, accredited by national standard setting bodies. National standards ensure that we are paying for value and that consumers are getting the best care possible. Substantial and growing evidence demonstrates that care delivered inside PCMHs is higher quality, affords better access, earns better patient experience of care scores, and is controlling costs. The evidence of PCMH effectiveness is extremely strong in our state Medicaid program. Medicaid has benefited from the shift to a PCMH-focused program in many ways including fewer non-urgent ED visits, fewer hospital admissions, 32% more participating providers, and a 2% reduction in per person costs. Naturally advocates are very concerned about eroding that hard-won progress and moving backward by rejecting national PCMH standards that are working.

Using successful national standards for PCMHs will avoid unnecessary state spending and would be extremely costly to replicate. NCQA, the most commonly adopted national PCMH standard, spent eight years and almost \$10 million developing their standards. PCMH certification is a complex process, as it should be to ensure consumers are getting what we pay for. Attached to this document is a copy of the standards for just one NCQA PCMH element, with its twelve detailed factors. PCMH certification includes six standards, 27 elements and countless factors. NCQA now devotes 35 FTEs to supporting practices during the transformation and application process. For example, many resources are devoted to answering practice questions about the standards such as "Does the way that we do that count?" It would require substantial state resources to duplicate national PCMH standards, the infrastructure to implement them, and to revise them as best practices and research evolves. The savings to Connecticut, in both time and money, of continuing to utilize national PCMH standards could serve much better purposes such as increasing provider payment levels, auditing PCMHs annually, glide path loans to more practices, quality improvement research, intensive care management for high risk patients, and learning collaboratives.

NCQA's program has considerable flexibility to work with states to tailor standards – required and optional – to each state's needs. Cultural competence and linguistic access standards that are optional under NCQA could be required. NCQA is now working with New York to develop a certification for school-based health centers. Oral and behavioral health care can be included within NCQA's flexibility and/or in annual audits/reviews as happens now in Connecticut's Medicaid program.

Concerns have been raised that small practices cannot accomplish practice transformation despite considerable evidence to the contrary. In fact, 89% of NCQA recognized PCMHs nationally have less than ten clinicians. Over 2,500 practices with one or two clinicians have earned NCQA recognition – the vast majority as Level 3 PCMHs (the highest level).

It has also been suggested that it costs practices \$200,000 for NCQA recognition. In fact, NCQA's price for PCMH recognition of a Connecticut practice with five clinicians is \$2,280 for three years minimal compared to reimbursements. In 2012, Connecticut's Medicaid program averaged \$150,000 in higher reimbursements to PCMHs – and that is only from one payer. There are staff costs to implement practice transformation (\$200,000 is probably an excessive estimate), but that is exactly the point of becoming a PCMH. Being available beyond usual business hours, referral tracking, arranging appointments, reminding patients, tracking down lab tests and X rays, daily team huddles and other PCMH functions will have a cost to implement at least initially, especially in a practice that is not currently providing any of these services. But those beneficial services are exactly what PCMH certification is meant to reward.

Concerns have been raised that NCQA does not audit practices between three-year certifications, but that is not entirely accurate. NCQA does audit a sample (5%) of practices, according to meeting materials. In addition during re-certification, NCQA looks backward at the practice's performance during their earlier PCMH certification period as part of the new evaluation. Our state Medicaid program goes further and reviews PCMHs annually between NCQA certifications to ensure that practice transformation is sustained. The bottom line however is that whatever NCQA is doing, whatever their "secret sauce", it is working – quality and access to care are improved and costs are moderated. The longer practices have had PCMH status, the better their performance.

As emphasized in the materials circulated for this meeting, PCMHs serve as the foundation for future health reforms. You can't build anything on shifting sand. Nationally recognized PCMHs serve as a strong, well-tested foundation for future delivery and payment reforms. In fact, one of the readings for this meeting noted that most states participating in the CPCI program used NCQA to certify PCMHs. Using existing, proven standards avoids delay and moves Connecticut toward long-overdue reforms.

The slides suggest a bias in favor of requiring payment reforms for PCMH recognition. While thoughtful payment reform is an important goal, creating a new barrier to PCMH transformation is unwise for two reasons. Currently, even without requiring financial risk and expanding practices' liability, PCMHs are controlling costs – there is no need to layer on required payment reforms. PCMH transformation to can

be difficult for practices; introducing a far more challenging requirement will reduce the number of new PCMHs in Connecticut and deny Connecticut the benefits of PCMH expansion.

The materials also emphasize the importance of building PCMHs into a health neighborhood. Connecticut's Medicaid program is in the final stages of designing a health neighborhood pilot for members eligible for both Medicare and Medicaid. Unlike SIM, that process has been open and inclusive, engaging all voices at the table in a thoughtful, well-informed, consensus-building process that is responsive to all concerns and respectful of all stakeholders. The MAPOC/DSS collaborative health neighborhood design should serve as a model to SIM for better policymaking.

There is also an inherent unfairness to infringing on national organizations' intellectual property rights by adopting their standards. These nonprofits invested millions of dollars and years of work in developing very effective standards. Connecticut policymakers using their work without compensation is neither appropriate nor fair.

I urge you not to unravel one of the only things working in Connecticut's health care system. I urge you to resist moving backward, and to commit to using nationally recognized standards for PMCHs in Connecticut's SIM model so we can all move on to the much larger, much harder challenges in reforming our broken health care system.



Questions about national vs. Connecticut-specific standards for patient-centered medical homes

Below are some things we've heard about the decision whether to keep using national standards to certify PCMHs or develop a Connecticut-specific certification standard, and some information related to those statements.

1. **"Connecticut's SIM plan is to make standards higher than NCQA¹ and other national standards"**
 - a. Minutes of early SIM[#] meetings tell a different story -- that the purpose was to allow for a less rigorous standard (see minutes of June 24, and July 8, 2013 SIM Care Management Committee meetings).
 - b. But if this is really the goal, Connecticut could easily make additional parts of NCQA's program "must pass" or add state-specific standards on top of NCQA' ("NCQA plus"). Many states make these changes and NCQA staff are happy to help with that.
 - c. In fact, NCQA is working with New York to create a new school-based health center PCMH certification.

2. **"The expense of getting certified isn't worth it for practices"**
 - a. It costs \$2,280 for a Connecticut practice of five for NCQA PCMH certification that lasts three years.
 - b. In 2012, the average Connecticut Medicaid PCMH averaged \$150,000 in higher reimbursements, far more than the NCQA cost.
 - c. The number of Connecticut providers applying for NCQA PCMH certification is up substantially this year over last.
 - d. The state could reimburse practices directly for recognition expenses. The Health Services and Resources Administration (HRSA) does this for Federally-Qualified Health Centers. This cost - along with the cost to procure support for practices to transform, which is critical - could be easily built into the SIM budget.
 - e. DSS and CHN have had great success in getting primary care providers to sign up as PCMHs for Connecticut Medicaid under the NCQA standards. As of May 8th there were 1,193 individual providers with NCQA certification in Connecticut's Medicaid program.
 - f. No providers have objected to the NCQA standards as a reason not to join the Connecticut Medicaid PCMH program.

3. **"It takes a lot of administrative time and can be disruptive to transform into a PCMH"**
 - a. Right, that's the point- to "transform" practices.
 - b. PCMH practices have to be open beyond usual business hours, have to track referrals, arrange appointments and transportation, among other PCMH functions.
 - c. SIM can provide assistance to practices to help them transform to a PCMH, as Connecticut's Medicaid program does through the glide path.
 - d. CHNⁱⁱⁱ reports that virtually no Connecticut Medicaid practices which begin the PCMH certification process through the glide path fail to follow through to full certification.

4. **"Some doctors report that nothing changed when their practice transformed; other doctors report that some PCMH practices aren't doing anything differently – they filed the paperwork but nothing changed"**
 - a. Hard to reconcile with #3 above, but . . .
 - b. We've heard from many doctors who've transformed into a PCMH and report substantial, very valuable changes – it was challenging, but worth it.
 - c. Depending on how a practice operates, some doctors may not directly experience the changes of becoming a PCMH. Other members of the team are making the reminder calls, arranging transportation, and getting lab results. Doctors may not see any of this, but practice managers and other members of the team will see the difference, and it matters to **patients**.
 - d. We may not be sure what is in the "secret sauce" of PCMH transformation, but the difference is seen in the better health outcomes inside PCMHs vs. non-PCMH practices, as in Connecticut's own recent experience in the Medicaid program. And that's all that matters.

5. **"Lots of practices provide PCMH functions but just don't have the certification"**
 - a. That's great, but if they want the extra financial rewards, they have to prove their value with certification. The whole point of SIM and payment reform is to be sure that we are "paying for value."
 - b. Many practices start the process of transformation with a gap analysis and find they have more room to improve than they imagined.

6. **"PCMHs are only certified every three years. They are slacking off the important PCMH functions in the interim when no one is checking."**
 - a. Care delivered in PCMHs is better than in non-PCMH practices. The evidence supports that the current schedule of re-certification is working.
 - b. The point assumes that providers are not interested in improving care for patients. Primary care providers didn't get in the business to deliver bad care and run on the proverbial 'hamster wheel.' Studies have shown physician satisfaction is better in PCMH practices.

- c. Connecticut's Medicaid program conducts annual reviews of PCMHs to ensure they are maintaining the core elements of the model between NCQA applications, as well as integrating care with each patient's oral and behavioral health providers. Other payers and/or the state could adopt this simple innovation to ensure compliance with PCMH standards and NCQA is itself considering such an innovation,
 - d. The new 2014 NCQA standards require practices to designate an individual(s) who are responsible for sustaining the changes within the practice.
7. **"PCMH status just identifies practices that were already providing better quality care."**
- a. Good - that means PCMH status recognition and the payments that follow are supporting better quality care, which is the point of value-based purchasing.
 - b. Most practices that have earned PMCH certification describe it as a demanding but valuable transformation in the way they provide care. We have spoken to many providers who were initially skeptical that transformation would make a meaningful difference in their practice, but, after earning certification, they were convinced.
8. **"NCQA and other national PCMH standards don't include my only priority (i.e. oral health, cultural and linguistic access standards)"**
- a. All health care issues need a strong foundation of comprehensive, coordinated care to be effective. Great oral health or other services provided in a setting with weak PCMH quality standards does not support overall health, and individual services won't be well coordinated if health care in general is not.
 - b. Many states work with national PCMH accrediting bodies to add state-specific standards, e.g. "NCQA Plus." Options include making otherwise optional parts of NCQA's program mandatory or adding state-specific requirements on top. This could include a requirement that providers coordinate with dental providers.
9. **"Small practices have trouble meeting national PCMH standards"**
- a. In fact 89% of NCQA recognized PCMHs have fewer than ten clinicians.
 - b. Over 2,500 practices with one or two clinicians have earned recognition - the vast majority at Level 3 (the highest level).

June 24, 2014

ⁱ NCQA certifies 80% of PCMHs nationally

ⁱⁱ Connecticut's State Innovation Model plan, developed by the administration in response to a federal grant opportunity, to radically reform health care for all Connecticut residents

ⁱⁱⁱ Community Health Network, Medicaid administrator for the state

PCMH 1: Patient-Centered Access

10.00 points

The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

Element A: Patient-Centered Appointment Access (MUST-PASS) 4.50 points

	Yes	No
The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:		
1. Providing same-day appointments for routine and urgent care. (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>
2. Providing routine and urgent-care appointments outside regular business hours.	<input type="checkbox"/>	<input type="checkbox"/>
3. Providing alternative types of clinical encounters.	<input type="checkbox"/>	<input type="checkbox"/>
4. Availability of appointments.	<input type="checkbox"/>	<input type="checkbox"/>
5. Monitoring no-show rates.	<input type="checkbox"/>	<input type="checkbox"/>
6. Acting on identified opportunities to improve access.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets 5-6 factors (Including factor 1)	The practice meets 3-4 factors (Including factor 1)	The practice meets 2 factors (including factor 1)	The practice meets 1 factor (including factor 1)	The practice meets 0 factors

Explanation MUST-PASS elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

All practices, including those with walk-in access, must make same-day scheduled appointments available and must monitor their availability. Walk-in access is an approach to patient appointment scheduling that allows established patients to be seen by a member of the care team during regular office hours, without prior notice.

The practice has a written policy for making appointments available for both urgent and routine issues. The policy states time requirements and defines "routine" and "urgent." For example, the practice has a policy that urgent issues are seen immediately and routine visits (e.g., new-patient physicals, return-visit exams to monitor mild acute and chronic conditions) are scheduled within seven days.

The practice triages patients to determine the urgency of a request for a same-day appointment; triage considers patient care need and preference.

Patients access the clinician and care team for routine and urgent care needs by office visit, by telephone or through secure electronic messaging.

Factor 1: Factor 1 is a critical factor and must be met for practices to receive a score on this element. Since this is also a must pass element, failure to meet factor 1 will result in denial of recognition.

The practice reserves time for same-day appointments (also referred to as "same-day scheduling") for routine and urgent care based on patient preference and need.

Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement.

The practice has a process for scheduling same-day visits for patients with routine and urgent needs, and monitors use of same-day appointments to ensure that patients are able to use this feature.

Factor 2: The practice schedules appointments outside a typical daytime schedule. For example a practice may open for appointments at 7am or remain open until 8 pm on certain days or it may be open two Saturdays each month.

Providing extended access does not include:

- Opening daytime appointments when a practice would otherwise be closed for lunch (on some or most days).
- Opening daytime appointments when a practice would otherwise close early (e.g., a weekday afternoon or holiday).

Practices are encouraged to first assess the needs of their patients for appointments outside normal business hours and then to evaluate if these appointment times meet the needs of the patients.

Factor 3: An **alternative type of clinical encounter** is a scheduled meeting between patient and clinician using a mode of real-time communication in lieu of a traditional one-on-one in-person office visit; for example, standalone communication or a combination of telephone, video chat and secure instant messaging. Group visits where the patient is one of several patients scheduled for care and education at the same time also qualifies as an 'alternative type of clinical encounter.'

Unscheduled alternative clinical encounters, including clinical advice by telephone and secure electronic communication (e.g., electronic message, Web site) during office hours do not meet the requirement.

Factor 4: The practice has standards for appointment availability. Availability standards may be established and measured for a variety of appointment types, including urgent care, new patient physicals, routine exams and return-visit exams or the practice may set a single standard across all appointment types (e.g. open access for all). One common approach to measuring appointment availability against standards is to determine the third next available appointment for each appointment type, with an open-access goal of zero days (same-day availability). Third next available appointment measures the length of time from when a patient contacts the practice to request an appointment, to the third next available appointment on the clinician's schedule. The Institute for Healthcare Improvement (IHI) identified third next available appointment tracking as "a more sensitive reflection of true appointment availability." IHI has set a goal of zero days for primary care.

<http://www.ihl.org/knowledge/Pages/Measures/ThirdNextAvailableAppointment.aspx>). A clinician's panel may be closed, but appointment availability may not be based on payer.

Factor 5: To provide consistent access and help understand true demand, practices monitor no-show rates. **No-show rates** may be calculated by taking the number of patients who did not keep their pre-scheduled appointments during a specific period of time (i.e. a session or a day) divided by the number of patients who were pre-scheduled to come to the center for appointments during the same period of time (Primary Care Development Corporation).

Factor 6: To expand access and capacity, the practice uses information gathered from reports in factors 1–5 to identify opportunities to improve access.

The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action.

Resource: One resource for the PDSA cycle is the Institute for Healthcare Improvement (IHI): <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>.

Documentation

*For all factors that require a **documented process** for staff, the documented process for staff includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.*

Factor 1: NCQA reviews a documented process for scheduling same-day appointments that includes a definition of routine and urgent appointments. NCQA reviews a report with at least five days of data, showing the availability and use of same-day appointments for both urgent and routine care.

Factor 2: NCQA reviews materials demonstrating that the practice provides regular extended hours. NCQA reviews a report with at least five days of data, showing availability and use of appointments outside the normal hours of operation.

Factor 3: NCQA reviews a documented process for arranging appointments for alternative types of encounters (e.g., telephone, group visits, video chat). NCQA reviews a report of encounter types and dates that includes frequency of scheduled alternative encounter types in a recent 30-calendar-day period.

Ad hoc telephone or email exchanges do not meet the requirement.

Factor 4: NCQA reviews a documented process defining the practice's standards for timely appointment availability (e.g., within 14 calendar days for physicals, within 2 days for follow-up care, same day for urgent care needs) and for monitoring against the standards. NCQA reviews a report with at least five days of data showing appointment wait times, compared with defined standards.

Factor 5: NCQA reviews a documented process for monitoring scheduled visits. NCQA reviews a report from a recent 30-calendar-day period showing number of scheduled visits; number of patients actually seen, number of no-shows; and a calculated rate using scheduled visits as the denominator and patients seen as the numerator.

Factor 6: NCQA reviews a documented process for selecting, analyzing and updating its approach to creating access to appointments that considers appointment supply and patient demand by:

- Including criteria for selecting areas of focus.
- Describing how the practice monitors areas of focus.
- Describing how the practice sets targets for improvement.
- Specifying how often criteria for creating greater access to appointments are revisited.
- Outlining when targets may be adjusted.

NCQA reviews a report showing the practice has evaluated data on access, selected at least one opportunity to improve access and took at least one action to create greater access.