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**Comments to Proposed Community and Clinical Integration Program
(CCIP) as Applied to the Medicaid Program**

I submit these comments concerning the Community and Clinical Integration Program (CCIP) being proposed by the SIM Project Management Office (PMO), and particularly for application to the Medicaid program. The CCIP is being presented as something which necessarily must be applied to Medicaid, even though at the one full Care Management Committee where it was discussed, on September 9th, there was skepticism expressed about its basic structure. Applying CCIP to Medicaid could undermine the great work that has been done in Medicaid with patient-centered medical homes (PCMHs) and CHNCT's intensive care management (ICM) program, setting us backward just when we are seeing improvements in care coordination. Beyond this, there is no source of funding for it, so pushing it on Medicaid could well require a diversion of precious DSS dollars, requiring further cuts to the Medicaid program.

In a webinar conducted about CCIP by the PMO consultant on September 22nd, the presentation had a slide suggesting that there were just some minor concerns with it by Committee members and that these have now all been addressed through some tweaking, versus basic structural concerns with CCIP as applied to Medicaid. In fact, written comments also were submitted raising questions about the premise of the design of CCIP. The PMO cannot represent that the Care Management Committee has approved, or recommended approving, the plan as applied to Medicaid.

Beyond this, although many of the CCIP initiatives on their face sound like they might be helpful in coordinating care, they could well be redundant with and even undermine the successful Medicaid PCMH and ICM programs already in place by interfering with what those programs are already doing, working at cross purposes with primary care provider-focused care coordination. As one example, the actions taken by the Comprehensive Care Teams (CCT) under CCIP in developing care plans, linking to specialists and then sending these individuals back to a PCMH could interfere with what the PCMH is already doing to

coordinate care of the individual. And, in general, the closer care coordination is to the individual's direct provider, as under the PCMH model, the more likely care coordination is to be successful. The CCIP is more of top-down approach.

Finally, at the September 9th Care Management Committee meeting, the PMO's Mark Schaefer conceded that there was no identified funding source for all of the mandates under the CCIP, although he hoped to apply for some grants. He suggested that perhaps DSS could be the source of the funding for CCIP in Medicaid. While DSS staff present indicated disagreement with that suggestion, the suggestion that DSS fund this largely redundant and potentially interfering initiative presents major concerns because the money would likely come out of other resources and services essential to the Medicaid population. We have already recently seen one severe cut to the Medicaid program directly harming access, in terms of cutting eligibility for HUSKY A parents; the last thing we should do is take money away from the program to support such an initiative with unclear utility which may even be counter-productive.

Of course, provider networks and FQHCs should be free to take positive aspects of the CCIP and voluntarily adopt them where appropriate for their practices. But any kind of unfunded mandate to do this would, for the reasons set forth above, likely do more harm than good.

In sum, the PMO is free to adopt the CCIP for the **non**-Medicaid population. But given the concerns raised with the basic structure of CCIP, a lot more discussion would be needed by the Care Management Committee with DSS before the Committee could recommend its adoption for the Medicaid program, and significant structural changes would likely be needed. The deadline of October 8th for the Committee to do this, based on the date of the next SIM Steering Committee meeting, as insisted upon by the PMO, is completely unrealistic. Since the Committee must provide robust input before DSS can make any decision about this proposal, neither the Committee nor DSS are in any position to recommend its application to Medicaid.

Submitted by:



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