

March 2, 2016

Honorable Nancy Wyman,
Lt. Governor
State Capital
Hartford, CT

Dear Lt. Governor Wyman:

We, the undersigned, are writing in support of the Community and Clinical Integration Program (CCIP) of the State Innovation Model (SIM), and the proposed use of CCIP standards in the implementation of the MQISSP shared savings program. We believe that CCIP is consistent with the direction that DSS has set for Medicaid and builds upon it by promoting health equity for all residents, regardless of payer. Please note that some of the signatories participated either in the Practice Transformation Task Force (PTTF), the Care Management Committee (CMC), or the SIM Steering Committee.

One of the major health reform issues resonating nationally and on the state level is the pressing need to link public and clinical health if health outcomes are to be addressed. Experts acknowledge that most factors impacting the health of the individual takes place outside the provider's office or the hospital room, but to date, the ability to link the community in which a patient lives with the health care system is limited at best. What is so promising regarding CCIP is its explicit purpose of developing stronger linkages and specific mechanisms to provide just such a connection for those most in need: individuals experiencing complex care, health inequity, and the lack of behavioral health integration. The program builds upon the proven pockets of innovation such as Camden's "hot-spotting" and Hennepin County's Community Care Teams.

Several issues were raised recently by some members of the Care Management Committee regarding inclusion, process, evidence, health equity, burden on the providers, and flexibility. All of these are important issues, and there has been an ongoing effort to address these over the last six months.

Inclusion: The PTTF is composed of a wide range of consumers, consumer advocates, physicians, and behavioral health providers, experts in community based care management, FQHC, APRN, health plans, and state agencies. It should be noted that this effort benefited tremendously from Kate McEvoy's participation on the PTTF. A list of the members is attached.

Process: At the CMC September 9, 2015 meeting, the CCIP program was presented and following this meeting a webinar regarding the standards took place on September 24, 2015. The first CCIP draft was published online in September 2015 with an open comment period in which many responded, including some CMC members. These comments were taken into consideration in subsequent drafts developed by the PTTF. On November 2, 2015, a webinar was held regarding CCIP standards and timeline to the CMC which served as another means of gathering input before the PMO and DSS worked to develop the third draft report and recommendations. On February 2, 2016, a joint meeting of PTTF and CMC was held although only a limited number of CMC members were able to attend. The final public comment period regarding the fourth draft of this report is open until March 2, 2016. We are grateful for this ongoing iterative process and the good faith efforts to "get this right".

Evidence: During this process the PTF based its recommendations on several sources: review of the literature (citations are provided in the fourth draft report), Center for Medicaid and Medicare Innovation’s technical assistance, interviews with subject matter experts and leaders that ran programs, as well as Connecticut stakeholders. The draft report provides more detail regarding design. Both Camden and Hennepin County’s efforts have been documented in the professional and public literature.

Health Equity: Medicaid has been very effective in leading its shift to the Patient-Centered Medical Home (PCMH) and reaching disparate populations, but equity in utilization does not equate with improved health outcomes. The reality is that African-Americans’ mortality from diabetes in Connecticut is 92.6 per 100,000 versus 47.5 for whites. In addition, while Connecticut sees an increase in the prevalence of diabetes, the increase in the disparity between white residents and African Americans is growing at an even faster rate (1995- 2013), which makes the need for clear standards and accountability even more pressing.

Burden on Providers: We appreciate this concern and indeed considered it as the benefit to patients were weighed. These deliberations benefited from the ongoing involvement of several providers that participate on the PTF. This is a period of turmoil for all providers with a growing number of Advanced Networks offering support to providers by providing individual providers with data and quality improvement programs. All are scrambling in this time of change, which creates an opportunity for CCIP to provide technical assistance and grants aiding this needed transition. This type of support has proven effective in the Medicaid program as it implemented the Patient Centered Medical Home (PCMH). Change is difficult, but CCIP provides a pathway to link the medical home to the community, positioning these providers to take advantage of the value based insurance designs of the future.

Flexibility: An issue was raised about the requirement that providers must participate versus a voluntary program. CCIP builds upon a design principle developed at the beginning of the SIM process – uniformity of standards and/or requirements. This request was made most often by providers wanting consistency. The premise of this program is that with standards all patients will benefit, and Medicaid clients will gain access to supports where they live that will substantially improve their wellbeing. With the uniformity of standards, those covered by commercial insurance will also benefit. We have to look no further than the testimony of families struggling with behavioral health issues during the town halls, regarding children’s behavioral health planning, to appreciate why behavioral health integration as a standard is so critical for all payers. Please note that the report does allow 15 months to fulfill the standards.

Again, we see this as a tremendous opportunity for Connecticut and in particular for Medicaid to lead in a profound way the transformation of health delivery. We thank Kate McEvoy and Mark Schaefer for leading this effort, and support the adoption and implementation of CCIP.

Thank you for your consideration.

Sincerely,

Alta Lash, Executive Director, UCAN
Member, Practice Transformation Task Force

Patricia Checko, co-chair
Consumer Advisory Board

Robin Lamott Sparks, Executive Director,
Coalition for New Britain’s Youth

Frances G. Padilla, President
Universal Health Care Foundation of CT

Member, Healthcare Innovation Steering Committee (HISC) and HISC representative to Care Management Committee

Jan VanTassel, Member, Healthcare Innovation Steering Committee

Sharon Langer, Acting Executive Director, CT Voices for Children
Member, Care Management Committee and Consumer Advisory Board

Arlene Murphy, co-chair
Consumer Advisory Board

Susan Lloyd Yolen,
Vice President, Policy & Advocacy
Planned Parenthood of Southern New England

Member, Health Care Innovation Steering Committee

Patricia Baker, CEO
Connecticut Health Foundation
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Tekisha Dwan Everette, PhD, Executive Director
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Grace Damio, MS, CD/N
Director of Research and Training
Hispanic Health Council
Member, Practice Transformation Task Force

Tom Swan, Executive Director
CT Citizen Action Group

Cc: Victoria Veltri, Co-chair, Healthcare Innovation Steering Committee
Kate McEvoy, Director, Connecticut Medicaid Program
Rep. Kathy Abercrombie, co-chair, MAPOC Care Management Committee
Mark Schaefer, Director, HISC Program Management Office