RODERICK L. BREMBY
Commissioner

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TELEPHONE
(860) 424-5053
TDD/TTY
1-855-470-3767
FAX
(860) 424-5057
EMAIL
commis.dss@ct.gov

November 28, 2016

Esteemed members of the Health Care Cabinet:

I affirm and applaud the membership of the Cabinet for holding a public comment session on November 15, 2016 to solicit testimony from interested parties on the Bailit recommendations. This revealed a useful range of viewpoints on many of the issues of interest and concern that were raised in the Cabinet's deliberations.

While the Department celebrates all available opportunities for open dialogue, it is extremely important that any such exchange focus upon facts. We were surprised and concerned by certain statements made by Qualdigm in its testimony to the Cabinet, and wish to correct several misstatements included therein.

- **Qualidigm represented that, "Connecticut is . . . refusing to move toward value-based contracting" and that "CT . . . continues to pay providers 100% on a fee-for-service basis."**

  This is not correct. The Department of Social Services (the Department) has since 2012 served Medicaid beneficiaries in a Learning and Action Network Alternative Payment Model (LAN APM) [see appended chart] 2A (Rewards for Performance) through its Person-Centered Medical Home (PCMH) initiative. This model provides enhanced fee-for-service payments, as well as performance and year-over-year improvement payments, to primary care practices that have received PCMH recognition. Further, the Department provides no cost practice transformation coaching to primary care practices through a multi-disciplinary team affiliated with its medical Administrative Services Organization, CHN.

  As of November, 2016, a total of **111 practices (reflecting 440 sites and 1,546 providers)** were participating in the DSS PCMH initiative. These practices were supporting **330,116 Medicaid members, almost 44% of the total served**.

  Further, effective January 1, 2017, the Department will launch Wave 1 of its PCMH+ initiative, a LAN APM 3A upside shared savings initiative with Federally Qualified Health Centers and advance networks. The SIM Model Test Grant Application commits Connecticut to a second wave of PCMH+ starting January 1, 2018.

  The Department's consistently expressed position has been that value-based contracting is an essential complement to the Department's existing and proposed care delivery reforms. We are simply arguing that there should be a careful, incremental developmental curve in implementing

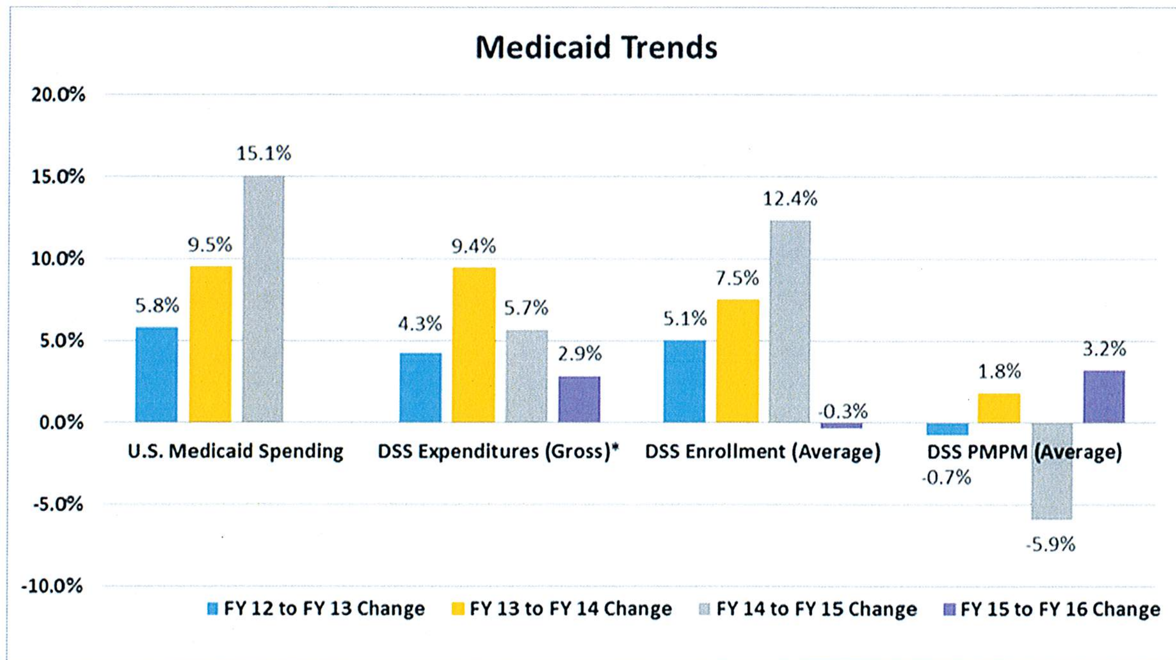
these strategies for Medicaid members, who face many more economic and social barriers to effective receipt of health services than is the case for privately insured individuals.

- **Qualidigm further represented, based on a back-of-the-envelope calculation, that, "the average cost per [Connecticut Medicaid] beneficiary is . . . up 36.4% over the last five years" and that "periodic external evaluations of our programs by third-party, unbiased groups with excellent reputations are needed to determine if progress is being made . . ."**

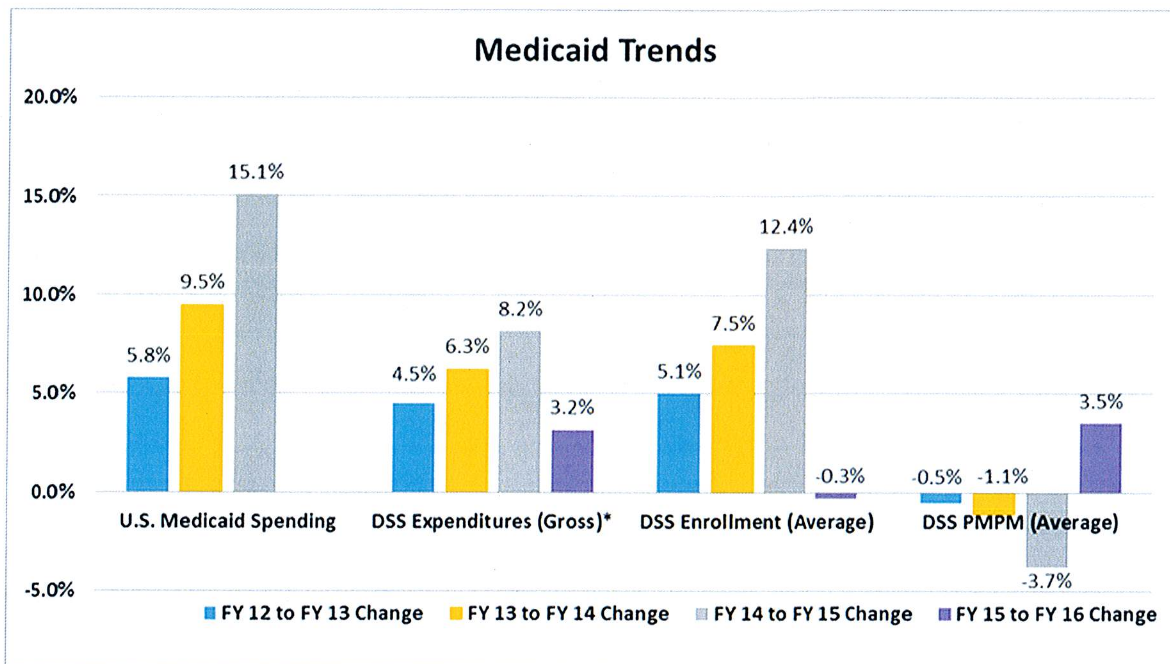
The statement concerning per member per month (PMPM) costs is not correct.

Since implementation of the Department's self-insured, ASO model in 2012, **per member per month Connecticut Medicaid costs have decreased by 1.9%.** Further, despite significant increases in enrollment, **Connecticut Medicaid expenditures have increased at a much lower rate than the national average**. Over the past four years, the Department has also documented significant improvements in many measures of health outcomes and care experience for members.

The chart below summarizes unadjusted PMPM changes over time, as measured on a date of payment basis.



The second chart indicates PMPM trends adjusted to remove any possible anomalies caused by significant changes in expenses for hospital supplements and settlements.



The Department agrees that third party verification of its calculations is important. To support transparency, these calculations are based upon publicly shared expenditure and enrollment reports. Please note the following excerpt from the fiscal accountability report produced by the General Assembly's Office of Fiscal Analysis [https://www.cga.ct.gov/ofa/Documents/year/FF/2017FF-20161115_Fiscal%20Accountability%20Report%20FY%2017%20-%20FY%2020.pdf]:

> ***Entitlements***
>
> *Entitlements are the largest category of fixed costs, representing 42% of projected fixed costs in FY 18. However, annual growth has been the smallest of all other fixed costs categories at 3.1% per year. Absent future specific state or federal policy changes impacting these programs expenditures are anticipated to increase consistent with current historical trends.*
>
> *Medicaid is the largest entitlement program projected to cost $2.9 billion in FY 20 (or 67% of this category of expenditures). The Medicaid program is projected to increase at an average of 5.5% per year for the period FY 17 to FY 20. The increase is due to (1) caseload growth and (2) changes in federal reimbursement associated with the HUSKY D population.* ***Despite projected growth in this area, per member per month costs have decreased each year for the period FY 12 to FY 15, ranging from -0.5% to -5.9%.*** *[emphasis added]*

The Department reports Medicaid expenditure data in considerable detail to the General Assembly's committees of cognizance on a monthly basis. This publicly available information is an

alternative means of supporting third party verification. Further, the Department is always willing and able to substantiate its own analysis with any interested party.

Thank you for the opportunity to set the record straight on these important points, as facts do matter.

Respectfully,

Roderick L. Bremby
Commissioner

Figure 1. APM Framework (At-A-Glance)