Consumer Advocates' Concerns with Connecticut's State Innovation Model Grant Proposal

The State Innovation Model (or "SIM") is a proposed state planning grant to restructure the Connecticut health system care system – payment and care delivery – for at least 80% of Connecticut state residents—involving all payers: commercial insurance, Medicare, Medicaid and self-funded plans, wherever "alignment" in payment methodology is possible.

The federal Medicare/Medicare agency, CMS, has reportedly stated that a requirement for approval of such a planning grant is that the proposal must include imposing financial risk on providers. This means imposing a financial incentive to deny care on such providers, since they will receive higher payments if money is saved on their patients. CMS has indicated that it prefers that these new models address "total cost of care. "

It is apparent that the state's driving force behind this effort is the desire to obtain a SIM implementation grant, estimated to be worth $40 to 60 million to state planners from CMS. A secondary driver among some proponents from industry and the state is an ideological disposition to impose financial risk on providers as the best way to save money in the health care system, despite a mixed record for provider risk models in saving money. Most recently this was highlighted by the withdrawal of nine very sophisticated Medicare Pioneer Accountable Care Organizations from CMS's flagship program. We have serious concerns for consumers because such a payment system will result in restricting access to care in many cases. And, especially given the very large expected impact on millions of state residents, it is deeply troubling that there is essentially no consumer representation in the small group of individuals designing this payment model, the process has been largely out of public view, and the proposal is being rushed to submission for September, with public outreach that only began in late June.

The proposal is fundamentally flawed both procedurally and in its substance. If adopted, it will necessarily restrict access to care and, in the case of Medicaid enrollees, undermine the innovative patient-centered medical home model, which is new, but showing early signs of great success. That model, well-vetted over years, built on thoughtful consensus with broad stakeholder input, has saved money and improved access to quality care in other states. We believe this innovation, addressing the same goals as the SIM proposal, should be supported and allowed to succeed before beginning a more radical, and counter-productive, initiative.

The Process Has Been Unacceptable

There are 75 individuals on the SIM Committee and its various workgroups. Of the 75 members, only three are identified as representing consumers. Of these three, one is a provider who consults for industry and government. Moreover, there are no individuals identified on SIM Committee documents as being consumer representatives either on the payment reform workgroup, where the critical and troubling financial recommendations are being made, or on the SHIP steering committee that will make all final decisions. By contrast, there are 15 insurer representatives and 23 providers among SIM committee members. The SHIP steering committee, which will make the final decisions on payment and care delivery for over three million Connecticut residents, includes no consumer representatives, but does include two providers and three insurers, with 15 of the 20 members working for state government.

Although the proponents say they are seeking broad input from stakeholders, this is belied by the lack of any meaningful consumer representation on the groups that will make the decisions about the recommended payment model. In addition, with an intended submission date in September, it is apparent that the input it intends to get in July and August (a time when obtaining input is difficult in the best of circumstances) will have no meaningful impact on the final proposal.

The Proposal is Deeply Flawed

At this writing, the proposal has been characterized by SIM leadership as very close to finalized. The substance of the proposal is fundamentally flawed for many reasons, including:

- Per the proponents, any system of payment reform under this grant will necessarily involve directly imposing financial risk on providers, whether it be the most "mild" form known as "shared savings" or full capitation (also called "prospective payment"). Under any such systems, there is an intentional financial incentive on providers to reduce the total cost of care for their patients. This can be accomplished in myriad harmful ways.

- Shifting risk to providers leaves consumers without a champion in trying to get payment for necessary treatment. In arguing with insurers, patients generally have doctors on their side. In this new proposal, however, patients will be arguing with their doctors for the treatment they need, and, worse, they may never even be told about more expensive options because of the provider's full or partial financial responsibility for those options.

- Connecticut has a very poor record of protecting consumers (or taxpayers) in any kind of capitated/risk-sharing environment, as demonstrated over many years in the case of the risk-based HUSKY managed care contracts, which were finally terminated in 2012 after years of poor performance, excessive costs and lack of accountability to the taxpayers.

- There is no need to invent an entirely new system of payment with these troubling direct incentives to deny care when Connecticut has already been developing, as part of health care reform, the innovative non-risk system of health care delivery and payment under the Medicaid person-centered medical home program ("PCMH") program.

- PCMH providers are paid under three methods: fee-for-service for health care services delivered, extra payments for care coordination services, and after-the-fact financial rewards for quality improvements. While the measures for obtaining these financial rewards are aimed at quality improvements which are expected to both improve care and save money (e.g., numbers of adults with in-patient admissions for whom there is a claim for post-admission follow-up within seven days of discharge date), incentive payments to PCMH providers are specifically not premised on money saved generally.

- If the SIM grant were adopted, it would require imposing financial risk on PCMH providers under Medicaid, thus undermining this promising new model while in its infancy.

- As hospitals in Connecticut merge, convert to for-profit status, and acquire physician practices, financial incentives will shift in ways that accelerate consumer concerns about incentives, just when transparency will decrease.

Even "Shared Savings" Will Harm Health Consumers

The harm to patients from capitating providers is readily apparent. But harm also will occur under a "shared savings" model. Such a narrowing of health care options is not consistent with the health care reform models that advocacy groups have long fought for on behalf of consumers denied appropriate care for financial reasons.

There have been suggestions that we need not worry about providers restricting needed or appropriate care to save money because there will be quality measures which must be met for the providers to participate in shared savings. But there has been no serious effort to develop meaningful quality measures. Moreover, this suggestion ignores the myriad ways in which providers with a direct financial incentive to limit care can do so to save money, while still technically meeting any quality measures that can be devised. Quality measurement in health care is in its infancy and the literature offers ample evidence of unintended consequences. Connecticut is among the worst states in both quality measurement and accountability of providers.

The Proposal Will Affirmatively Harm at Least Medicaid Enrollees

There are particular challenges facing low-income Medicaid enrollees, compared with the population of health care consumers generally. These individuals are more likely to suffer from multiple chronic conditions, serious mental illness, and heavy reliance on medications. Further, due to higher incidence of low education levels and English literacy issues, they are often less able to advocate for themselves.

In addition, while few would disagree that there is some legitimate concern with over-utilization under any fee-for-service system, that concern is far less relevant to the Medicaid population, which already has serious access problems. The last thing low-income Medicaid enrollees need is for their providers to have yet another incentive not to provide them with care, as is inherent under the grant proposal.

In light of these realities, the PCMH model, under which a primary care provider is compensated for coordinating care and acts as an honest broker without any financial incentives to deny care, ensures critical protections, while reforming payment to reward quality.

Since the SIM proposal involves placing financial risk on providers, it will be harmful to all health consumers, but particularly those on Medicaid. It will undermine the innovative PCMH model of payment reform that Connecticut has invested in and is just now getting off the ground for Medicaid enrollees. If anything, it is PCMH, with its dedicated payments made to providers for care coordination and for performance on quality measures, which should be the model adopted for all payers, rather than the risk model being pursued under the SIM grant.