Connecticut Health Policy Project

Issue Brief

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What is SIM and why should we care?

What is SIM?

The State Innovation Model (SIM) is Connecticut's plan to fundamentally transform our broken health care system – both how care is delivered by doctors, hospitals and other providers, and how it is paid for. Connecticut will spend $40 billion on health care this year[i], and like other states, that spending is rising faster than the rest of the economy. SIM is meant to reform health care for every state resident – all 3.5 million of us. It includes Medicare, Medicaid, state and other public employees, private employer coverage, state insurance exchange coverage, self-funded and fully insured, union and non-union coverage, individual and small group coverage – everyone.

Why are we doing this now?

This isn't a new problem and Connecticut has made attempts in the past to address the issue, but this time we received a $3 million federal grant. The state has used the grant to hire new state employees, across agencies and UConn, and outside consultants. The "deliverable" for the federal grant is to develop a grand, all-encompassing health system reform plan for Connecticut and to submit an application for a second-round federal grant to implement the plan. In the second-round grant, Connecticut will compete with fifteen other states also developing plans for grants of $40 to $60 million.

Who is doing the SIM planning? What is the process?

The plan was developed by a SIM steering committee and three workgroups – payment reform, care delivery and health information technology. Despite getting the federal award in February, the committees met over just a few weeks this summer, ending their work in August. Meeting notices were buried on the website of the now-defunct Office of Health Reform and Innovation. Meetings were held, often in the evenings, in an office building in Rocky Hill, at CT Valley Hospital in Middletown, and in the Governor's Capitol 4th floor conference room. No notices were published in the legislative bulletin.

Who is on the committees? Who is left out?

Seventy percent of the SIM steering committee members are from state agencies; other members include two insurers, two foundations, a doctor and a large company. There were, and are, no independent consumers, consumer advocates, hospitals, legislators or legislative staff on any of the SIM committees.

What is the current SIM plan?

The SIM plan includes expanding medical homes, and putting providers at financial risk. They changed the name of person/patient-centered medical homes (PCMH) to advanced medical homes. They intend to create new, lower, Connecticut-only medical home certification standards bypassing national accrediting bodies like NCQA and JCAHO. There are currently 821 NCQA certified PCMH providers in Connecticut[ii] and the list grows every month.

The proposed payment model, Total Cost of Care (TCC)[iii], places financial control of patient care on those medical home providers. TCC gives providers unparalleled control over health care finances, allowing them to share in any savings they are able to generate on their own patients' health care. This payment model is very new; sophisticated groups in other states are struggling to make this work.

Under the SIM model, providers will have a direct financial incentive to control costs. However, TCC includes either "shared savings" or capitation. In shared savings, providers get paid for the services they provide under the usual fee-based system, but, on top of those payments, they also share in any savings from patients who end up costing less than they otherwise would have. The shared savings payments are in addition to their regular fees. In some forms of shared savings, called "down-side risk," providers also lose money if their patients end up costing more than they otherwise would have been expected to.

Capitation goes further in granting providers a set amount of money for each patient's total care for a specific length of time. If the actual costs of care for that patient are less, the provider keeps the money. But if costs are higher than the capitated amount, providers have to take the loss. Capitated rates are "risk adjusted" by actuaries based on patient characteristics and expected and/or historic health care needs.

The math and the assumptions to develop those TCC cost level expectations, capitated rates, and risk adjustment are complex and highly charged. That area of health financing is still developing.

SIM quality measures and improvement plans are vague and providers must only reach "minimal" quality standards to receive TCC financial incentives. The process to define those minimal standards and the decision-makers are yet to be defined.

How far along are they?

The plan is almost complete. Only minor design questions remain. We expect a final draft later in October.

Will there be opportunities for public input? Is there still a chance to change it?

We don't know if there will be opportunities for public input before the plan is submitted to the federal agency. We also don't know if SIM leaders are open to changing any parts of the plan, especially the central element of its payment model: of entrusting providers with financial control over each patient's care.

Has Connecticut tested TCC in the past?

Yes, both our HUSKY and state employee plans used to be capitated but we moved away from that model in both plans, saving money[iv] and improving access to care[v]. The HUSKY plan moved from capitation to a PCMH-based model based on studies finding that the state was overpaying insurers[vi] and provider lists were not accurate.[vii] Under capitation only 57% of HUSKY children got check ups and most of them were not complete. Under the HUSKY capitated TCC program, a DSS secret shopper survey found that consumers could only get appointments with one in four providers on the insurer's lists[viii]. Progress toward improving those rates actually slowed when Connecticut instituted TCC[ix]. Not much has changed since then, in terms of Connecticut's ability to track funding, access to care, under/over treatment, or quality of care.

Can they do this across all payers? Don't they need legislative approval?

Yes, they can do this across all payers. And no, they don't need legislative approval. If there isn't a law limiting it, it can happen. In the 1990s, insurer capitation/managed care swept across Connecticut's health care landscape without legislative approval or pilots. It took several years of legislative advocacy to enact common sense managed care reform legislation to fix some of the problems. Eventually managed care disappeared, both because of consumer concerns and because the savings evaporated. The federal ERISA law is not a barrier. ERISA is a limit only on states' ability to regulate self-insured plans; it is not a limit on what plans want to do anyway. It is possible that SIM may need legislative committee approval for a Medicaid state plan amendment but it may not.

What's the problem? What are the risks?

Advocates have sent a letter with our concerns[x] to SIM leaders. As of the beginning of October, we have not received a response. We are concerned that the most essential stakeholders, consumers and their advocates, have been excluded from the SIM process. We are concerned about the lack of transparency and the speed of the process. We are concerned that TCC is new and that more sophisticated and mature TCC programs in other states are struggling.

Concerns with the TCC model focus on questions about the system's capacity to protect consumers' health. TCC is meant to reward providers who save money on their patients' care. There are essentially two ways for providers to save money on health care. The right way is to eliminate duplicate tests, unnecessary care, and inappropriate overtreatment. The other way is to withhold necessary care, which is what routinely happened in managed care, when we granted financial control to insurance companies under a TCC model.

Unfortunately, unlike other states, Connecticut does not have a robust quality monitoring system to distinguish between the two ways to save. A monitoring system would track the use of care by patients, ensuring that the right person receives the right care at the right time at the best price. A good monitoring system can detect under-treatment -- when people aren't getting the care they need-- as well as overtreatment -- when people are getting too much or inappropriate care. Implementing TCC ***before*** we have a strong quality monitoring system in place is irresponsible. And a good quality control

system based on this monitoring would deny any shared savings to a provider who reduces costs by significantly under-treating patients.

Connecticut's health care community is undergoing seismic shifts right now. The Affordable Care Act is making thousands of changes, big and small. Several Connecticut hospitals are in various stages of converting to for-profit status, raising grave concerns about quality when profits drive care decisions. Compounding this, a growing number of private practices are being purchased by hospitals. Making significant TCC changes to provider financial incentives at this point is inviting unintended consequences.

Who benefits? Who is at risk?

Stakeholders that stand to benefit from TCC include hospitals, other providers, insurers, government, and employers. Providers, particularly those associated with the new, lower standard medical homes, also will benefit by gaining control over their practices, over patient care, and potentially substantial financial rewards by lowering the cost of caring for their patients. As the largest, best capitalized providers in Connecticut, hospitals will likely be a large part of and share in those provider incentives to lower costs. Insurers benefit by shifting financial risk onto providers, while maintaining their administrative revenue. Government, employers and other payers benefit by incentivizing providers to do the hard work of lowering costs and by moderating their own risks and thus costs.

Consumers and taxpayers, however, could lose significantly under TCC. Currently when advocating with an insurer to cover necessary treatments, patients generally have providers on their side. Under TCC, we will be making our plea to providers, and the cost of care will come out of that provider's bottom line. In fact, patients may never hear about costly but effective treatment options from providers under the TCC economic model. Taxpayers will be at risk if patients denied necessary care eventually end up on public programs.

What are other states doing with their SIM grants?

Connecticut advocates are talking with advocates in other states about their SIM processes. Most other states have large, public, diverse stakeholder meetings that include consumers and advocates. Maryland's SIM planning is remarkable. They started Local Health Improvement Coalitions in 2011 with diverse membership – consumers, advocates, community organizations, schools, public health, legislators, plus all the stakeholder groups included in Connecticut's SIM – and are using their All Payer Claims Database (APCD), advanced analytics and performance/quality monitoring to identify hot spots and other problems, uniting the entire health system to create local solutions. (An APCD combines health care claims across programs, Medicare, Medicaid and private insurance to better track spending, quality issues and access to care. Connecticut is beginning to build an APCD.) Maryland intends to use the SIM grant to build on their local quality coalition capacity. Payment reform is a much smaller part of their plan; quality is clearly the priority.

Colorado also has an exciting SIM process. They have a strong APCD and are also using the data to target quality and access interventions. They have a large, diverse, public stakeholder group, including

advocates and consumers, that meets monthly. They have a strong stakeholder and public input process, including inviting written public comment on the final plan. They even hired a consumer organization to write the patient-centered care part of the plan.

Didn't I hear that CMS is telling us that we have to include provider risk in our grant application to have a chance of getting the $50 million?

We heard that too. But SIM leaders and consultants couldn't furnish us with any documentation, meeting notes or sources for that statement. When we asked CMS directly about it, they didn't say that. In fact, the FAQ on the federal SIM site says there is no preferred payment model; there is a preference for building on models that are already working in the state.

Are they planning to start with pilots?

Unfortunately, no. Connecticut's failed venture with HUSKY capitation through insurers was implemented across the state over just a few months. There was no time to evaluate impact, identify challenges and design solutions. SIM leaders are planning the same implementation pattern for TCC, rolling out along a pre-set timeline with at least 80% of state residents in a TCC payment arrangement by the end of the five-year grant period. There are no provisions in the plan to monitor, evaluate or adjust the model or timeline.

But what we have now isn't working either. Don't we need some kind of change?

Yes, and things are changing – in sensible ways, based on best practices by building consensus across all stakeholder groups, including consumers and advocates. Engaging the wisdom of all voices not only makes better-informed policies, but also engages all stakeholders in the hard work of making reform successful.

Fortunately, Connecticut has innovative health care models with wide support that show great promise. Our growing Person-Centered Medical Home program is already providing expanded access to efficient, coordinated care to over one in three Medicaid consumers and attracting new providers to the program. Providers in that program that excel in delivering quality care are earning performance bonuses. It's important to note that underpaid Medicaid providers are achieving the meaningful PCMH standards set by NCQA. Building on this success, we are poised to implement Health Neighborhood pilots for frail elders and people with disabilities eligible for both Medicare and Medicaid. Health neighborhoods will engage the entire health care system with social supports to keep people well, promote quality, protect patients, and responsibly share savings with providers. Both programs were designed in inclusive public processes, engaging the wisdom of all voices, and the final models are much stronger for it.

Isn't TCC happening now? Shouldn't we get ahead of it?

Yes and no. TCC arrangements are just beginning to creep up in provider contracts in Connecticut. SIM leaders have claimed that up to 62% of Connecticut providers are already in such arrangements[xi] but significant questions have been raised about the methodology to reach that number, the populations included, and the percentage of consumers in such arrangements.[xii] The best information, from

Connecticut medical/professional societies and providers, is that a few large provider groups are testing TCC, that TCC is rare in our state, and that it covers a very small number of consumers.[xiii] We are far behind neighboring states in these arrangements. We can wait to see if TCC is successful or not and benefit from others' experience.

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[i] Calculation from National Health Accounts, CMS
[ii] NCQA recognition directory, accessed Sept. 25
[iii] SIM leaders recently changed the name of their model from Total Cost of Care to Shared Savings. However the definition and model remain unchanged; the change was made to find a "less controversial" label, Sept. 17 SIM steering committee meeting. SIM presenters made clear that capitation, the most controversial model, is still included in the new definition.
[iv] HUSKY B saves $4 million in Switch from HUSKY HMOs, Dec. 2012
[v] Early results on CT's state employee wellness program encouraging, Feb. 2013
[vi] Comptroller's audit finds $50 million savings in DSS budget, May 2009
[vii] Mystery Shopper Project, Mercer for DSS, October 25, 2006
[viii] ibid
[ix] Well-child care in Medicaid: How is Connecticut doing?, CT Health Policy Project, Nov. 2001
[x] Aug. 22 letter to Lt. Gov. Wyman from 24 consumer advocates
[xi] September 17, SIM steering committee presentation
[xii] Sept. 24 letter to Dr. Mark Schaefer from Ellen Andrews PhD
[xiii] ibid