November 12, 2013

The Honorable Nancy Wyman
State Capitol
Hartford, Connecticut
LtGovernor.Wyman@ct.gov

Dear Lieutenant Governor Wyman:

We are writing to thank you for meeting with us on Wednesday to discuss our concerns about development of the State Innovation Model (SIM) project outlined in our August 22, 2013 letter. We were encouraged to have our concerns acknowledged, and appreciated the opportunity to discuss possible solutions.

As independent advocates for Connecticut consumers, we remain fully committed to the vision of redesigning Connecticut's fragmented health care system to promote quality and keep coverage affordable, for everyone, following the maxim of "do no harm." It is this maxim that precipitated our request for this meeting. We summarize below our concerns expressed at the meeting and also provide a clear statement of what we believe are the minimum protections necessary to prevent such harm, which must be included in the final SIM plan.

It is imperative that payment reform not reward denials of necessary care, as was the history of managed care in Connecticut. As we noted in our earlier letter:

> "To ensure savings are not generated by sacrificing quality of care, no incentive dollars should be paid to providers that do not meet meaningful not minimal quality standards. This is more than denials of care, but total quality of care. We note that, in a provider risk model, consumers may not ever know about more expensive, but more effective, care options. Those cases would not show up on a denial of care measure."
>
> *-- August 22 2013 letter from 24 consumer advocates to Lt.Gov. Wyman*

The current draft SIM plan does not commit to denying financial incentives to providers and provider organizations found to have generated those savings at the expense of needed care for their patients, despite encouraging conversations and requests for language (attached). While we appreciate that you and the SIM project directors stated at the meeting that you do not disagree with this requirement, you also did not commit to putting this language in the final plan. to include this foundational consumer protection

We also remain concerned about the lack of independent consumer advocate input into SIM decision-making. Many of the current problems would have been avoided with meaningful independent consumer advocacy representation from the beginning. We urge you to remedy this failure immediately as critical decisions are being finalized.

We are also troubled by the lack of public accountability and transparency in the process to date. We understand the latest decision not to include consumer protections against profiting by denying needed care in the draft plan was made in a private conversation or meeting. Critical decisions, and the reasoning and interests of those making those decisions, must be public for the plan to have credibility and any hope of success.

We are troubled that language excluding downside risk from the Medicaid program, in which providers must share in losses from patients whose care costs more than estimates, has been weakened in the latest SIM draft plan. Medicaid has suffered from a long history of overpayments to insurers, under-service to consumers, and low provider participation. The shift from insurer risk, the implementation of person-centered medical homes, and subsequent administrative reforms have reversed those trends and the program is beginning to attract new providers. At the same time, total spending on Medicaid in FY 2014 grew only 3% from the year before, far lower than other health programs. A downside risk model would endanger this progress in a program that will grow substantially in the next year to cover close to one in four state residents.

Finally, we are troubled that less potentially harmful payment reform options than the very new, untested, open-ended shared savings model SIM proponents have championed apparently were not considered. Models such as the successful person-centered medical home Medicaid program and bundling payments for episodes of care were not seriously considered, likely because there were no independent consumer advocates at decision-making tables. Bundling among providers is not uncommon in Connecticut, addresses more expensive specialty care, and allows clear tracking for under-treatment and poor quality care. The only mention of bundling in any minutes or documents from the SIM payment reform committee indicates that it was discussed June 3rd, but then dismissed based on the assertion that "The Centers for Medicare and Medicaid Innovation [CMMI] are looking for a total cost of care model." However, the bundling payment model is featured prominently as an example of an innovative model in CMMI's Health Care Innovation Awards slides from July 11, 2013 and other states are featuring bundling in their SIM proposals.

In sum, we continue to be concerned about the non-inclusive nature of the SIM process to date and, not unrelated, the deficiencies in the model that that process has produced. But is not too late to remedy these serious shortcomings. The final SIM plan must make a clear, unequivocal commitment that:

- Providers found to have denied or restricted access to necessary care will be prohibited from receiving shared savings or other financial rewards
    - Robust quality measures of under-treatment which are the basis for denial of shared savings, including inappropriate denials or limitations on care or avoidance of expensive patients, must be

developed in an inclusive committee with significant independent consumer advocacy membership
    - The system to measure and sanction under-treatment, and a fair process to resolve disputes, will be in place **before** any provider incentives are implemented
- All decisions will be reached in a transparent, public process based on significant public input
- Independent consumer advocates will immediately be added in meaningful numbers, before the plan is finalized, to all SIM committees, along with other missing stakeholder representation
- As in the first SIM plan draft, downside risk payment models are excluded in the Medicaid program

Again, thank you for taking the time to meet with us. We are excited about the opportunity the SIM process holds to improve Connecticut's health system. We remain willing to work constructively with policymakers to make that vision a reality.

Respectfully,

Judith A. Stein
Center for Medicare Advocacy

Steve Karp
NASW-CT

Martha Stone
Center for Children's Advocacy

Daria Smith
Connecticut State Independent Living Council

Linda Wallace
Epilepsy Foundation of CT

Joy Liebeskind
CT Medical Home Initiative at FAVOR

Tom Swan
Connecticut Citizens Action Group

Kristen Noelle Hatcher and Kevin Brophy
Connecticut Legal Services

Kevin Galvin

Small Business for a Healthy CT

Julie Peters
Brain Injury Alliance of Connecticut

Sheldon Toubman
New Haven Legal Assistance Association

Kathi Liberman
Conn. Association of Residential Services Coordinators in Housing

Jonathan Reiner
Connecticut Coalition on Aging

Ellen Andrews
CT Health Policy Project

Jean Rexford
Connecticut Center for Patient Safety

Jan VanTassel and Abby Anderson
Keep the Promise Coalition

Karyl Lee Hall
Connecticut Legal Rights Project

Eileen M. Healy
Independence Northwest, Inc.

Sue Nesci
Arthritis Foundation -- Connecticut

Alta Lash
Caring Families Coalition
United Connecticut Action for Neighborhoods

Kate Mattias
NAMI -- Connecticut

cc: SIM SHIP Steering Committee

Consumer under-treatment protections language, as requested by SIM leaders:
In Value-Based Payment Strategy Section
Additions are underlined, deletions are [bracketed]

p. 57 to 58 – paragraph that begins Shared savings payment models offer a range . . .

In addition, we will adopt advanced analytics to identify outliers for underuse. To correct for incentives to generate savings at the expense of needed care, providers who are found to have inappropriately under-served patients, through denials or limitations on the amount, duration, scope, type or level of service prescribed, will be excluded from shared savings payments. In addition, as discussed in the performance management section, providers will be rewarded based on both their quality and efficiency performance.

p. 59 – bullet list under Guidelines for Payer Reward Structures
Add under second bullet (Both P4P and Shared Savings should reward both absolute performance and performance improvement)

-- Providers will not be rewarded if audits demonstrate inappropriate under-service, including through denials of care

p. 60 –

changes to second paragraph—

"As Connecticut pursues a shared savings program, there is [the possibility] concern that [a few] providers might seek savings through inappropriate means, including under-service for their patients, just as the fee for service system encourages over-service."

changes to third paragraph—

It is critical to ensure that providers do not benefit financially from savings generated at the expense of appropriate care delivery. We believe that it is important to establish an integrity-like function that focuses on these issues of risk avoidance and under-service[, including establishing guidelines for consequences of under-service (e.g. may lead to discontinuation of shared savings participation or network disenrollment)]. Providers who, based on the integrity-based functions and audits, are found to have inappropriately under-served their patients, as described above, will be disqualified from receiving shared savings incentives.

p. 60-- Delete 5th paragraph (that begins – The Equity and Access Council may also recommend . . .) and replace it with:
The Equity and Access Council will develop fair grievance, appeal and resolution processes for providers who dispute audit findings. The Council will also develop a system to provide technical assistance, enhanced monitoring, improvement plans, and other necessary support for providers and practices that need to i