November 26, 2013

CT Office of the Healthcare Advocate
Hartford, Connecticut
Attention: Victoria Veltri, Healthcare Advocate
sim@ct.gov

Re: Draft State Innovation Model Plan public comment

I am writing on behalf of the Connecticut Health Policy Project in response to the administration's State Innovation Model (SIM) draft State Innovation Model Plan Draft 1.1. Our comments follow previous correspondence from July 22, August 22, and November 12, 2013, joined in by many other advocacy groups around the state. Attached is draft consumer protection plan language, requested by SIM leaders and provided October 30, 2013.[1]

The Connecticut Health Policy Project is a non-profit, non-partisan consumer advocacy organization working since 1999 for quality, affordable health care for every state resident. We provide individual consumer assistance navigating Connecticut's challenging health care system, policy analysis and options for state, local, federal and regional policymakers, and education and training to build health policy capacity in our state. As independent consumer advocates, no one is more aware of the need for reform of Connecticut's health system and no one is more committed to finding feasible solutions that improve quality, protect consumers, and control costs. Above all, we are guided by the universal maxim to "do no harm".

There is much to be proud of in Connecticut's health system, particularly in recent years. Medicaid's shift from capitated managed care organizations (MCOs) to a non-risk administrative services organization-led system that focuses on care coordination has resulted in impressive quality and access improvements while controlling costs. From January 2012, when the MCOs left the program, to this June the number of providers participating in Connecticut's Medicaid program has grown 32%, hospital admissions are down 3.2%, the average length of hospital stays is down 5%, and cost per admission is down $200 (2.7%). Non-urgent care visits to the emergency department are down an impressive 11.7%, suggesting better access to preventive and maintenance care.[2] Total Medicaid expenditures from FY 2012 to

[1] Language refers to SIM plan draft 1.0 page numbers
[2] DSS presentation to CT Medical Assistance Program Oversight Council, October 11, 2013.

FY 2013 grew only 3.9%[3] while program enrollment grew by 6%.[4] Medicaid's Person-Centered Medical Home project now covers one third of all members, providing improved access to coordinated, team-based care centering on the needs and strengths of members.[5] The developing Medicaid/Medicare Health Neighborhood innovative model promises to provide access to coordinated, holistic, patient-centered care for fragile state residents eligible for both programs while controlling costs for both payers.[6] The Connecticut Health Policy Project appreciates the remarkable success achieved by policy-makers in a few short years and stands ready to support the state in maintaining this level of progress into the future.

Despite recent progress, Connecticut has struggled with past reform efforts and our accomplishments are fragile. Health reform now will face significant challenges including changing payment rates to providers for virtually all payers, hospitals buying physician practices, hospitals converting to for-profit status, and very high premiums in our health insurance exchange. Affordable Care Act coverage expansions will stress the system's capacity, especially for largely adult new Medicaid enrollees entering a program that has had problems getting adult medicine providers to participate. Connecticut does not yet have an All-Payer Claims Database or a statewide Health Information Exchange.

We support many of the findings and recommendations in the SIM draft plan. Many echo earlier work by consumer advocates and others in previous Connecticut reform reports. However, the process to develop the plan and some of the recommendations are troubling. We are concerned that the process was not transparent or inclusive, the payment model could cause serious harm to people by incentivizing stinting on care, and that a lack of trust in the process will lead to failure.

We are especially concerned that the proposed SIM payment model, shared savings, without strong protections against inappropriate under-treatment, or "stinting" on care, will create incentives that could cause harm to fragile consumers. To guard against this we proposed developing a system of monitoring for inappropriate under-treatment, in place **before** potentially harmful shared savings incentives are implemented, and denial of shared savings payments when under-treatment is demonstrated. These protections would serve to realign incentives toward productive cost controls such as reducing duplicated care, fragmentation, and inappropriate over-treatment. Upon request of SIM leaders, we drafted plan language to include this improvement (attached). We were disappointed when the

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[3] State of Connecticut Office of the State Comptroller. Monthly letter to the Governor, September 3, 2013, page 14 State of Connecticut Office of the State Comptroller. Annual Budget Report of the State Comptroller for Fiscal Year Ending June 30, 2012

[4] Active Assistance Unit reports, DSS, monthly averages each fiscal year

[5] 2012 PCMH Performance Measurement Summary, MAPOC Care Management Committee meeting, September 11, 2013.

[6] Health Neighborhoods 101, DSS, October 4, 2013.

language was not included in the draft circulated for public comment and urge its inclusion in the final plan.

We are concerned that the current payment model is not feasible for the large majority of Connecticut primary care physicians working in small practices.[7] Small groups do not have access to the same data and analytic tools as larger, hospital-affiliated groups to track patients' history, needs, costs or previous care. Small primary care practices are unlikely to have capitol resources to accept any financial risk. Independent, small practices have few levers to control costs or the quality of care delivered by specialists or hospitals. Independent practices have no reliable information on prices, which can vary enormously, to help consumers choose efficient care, even when there is a choice.

The SIM plan was developed over a very short timeframe, particularly for a state like Connecticut that is just beginning to embrace reforms, the process was not transparent, and critical stakeholders were not included. While we understand the tight timeframe was dictated by the federal grant process, many stakeholders, including those involved in the SIM process, are very new to the complex, evolving field of health reform. As outlined in previous correspondence, critical SIM meetings were held outside public view without public notice. This is the first official opportunity for public input. Many SIM participants and observers have noted that important decisions, most pointedly the payment model, were pre-determined. "Syndication" to consumer and other groups did not fully explain all aspects of the plan, especially the problematic payment model. For instance, the description of inadequate under-treatment protections in the SIM Consumer Draft Plan Summary is deceptive -- implying protection but omitting the plan's lack of enforcement standards or the need to have monitoring in place **before** potentially harmful payment incentives are implemented.

> "We will monitor providers to make sure that they are reducing costs in appropriate ways. By doing so, we will help make sure that providers do not reduce costs by withholding necessary services." (SIM Consumer summary)

In contrast, the Provider Summary language is very different, relying on tenuous, future, potential consequences of under-treatment.

> "Denial of necessary care is discouraged because providers are responsible for the downstream impact of withholding necessary care." (SIM Provider Summary)

In contrast to Connecticut's successful Medicaid Health Neighborhoods and Medical Assistance Program Oversight Council processes, the SIM process was not inclusive, excluding critical stakeholders, including independent consumer advocates. Medicaid policymaking has a practice of engaging all critical stakeholders and the

[7] 70% of Connecticut primary care physicians work in practices with 4 or fewer physicians, CT State Medical Society communication

program is stronger for that input.[8] In fact, national experts have highlighted engaging all stakeholders as a critical best practice for successful SIM projects.

> "For example, given time constraints and political impediments, SIM officials may be tempted to initiate a planning process that excludes key stakeholders (such as public health or consumer advocates) or ignores their concerns, resulting in lack of broad support for the plan. ***It is imperative for state SIM officials to listen to these stakeholders and communicate that they are being heard during the design and testing phases, to alleviate anxiety and address emerging concerns***."
> (Bold and italics included by authors in document, Commonwealth Fund Issue Brief, September 2013)[9]

In contrast, Arkansas's successful SIM project builds on two years of reforms, developed with all stakeholders at the table, and is focusing on less restrictive, more prudent episode-based payment models. Further, responding to stakeholder input, Arkansas SIM policymakers shifted to retrospective episode-based payment modeling, reconsidering their initial plans for prospective bundling payments to ensure universal buy-in, engaging all stakeholders in the success of the program.[10]

To ensure success and that no harm is done, it is critical that the final SIM plan 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

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[8] Two consumer advocates have been added very recently to the SIM Steering Committee, but after critical decisions have been made with very little likelihood of impacting the plan.

[9] S Silow-Carroll and J Lamphere, State Innovation Models: Early Experiences and Challenges of an Initiative to Advance Broad Health System Reform, Commonwealth Fund Issue Brief, September 2013

[10] Bending the Medicaid Cost Curve, Capitol Ideas, CSG, May/June 2013; Arkansas's Unprecedented Use of Performance Pay to Contain Health Care Costs, Governing, July 2013

- Independent consumer advocates will be included in meaningful numbers on all SIM committees

- As in the first SIM plan draft, downside risk payment models are excluded in the Medicaid program

While Connecticut's health system needs reform, we are making progress. Our state is currently experiencing important shifts in policy and payment across sectors and payers with uncertain outcomes. While the federal SIM grant offers resources to support reform at a time of tight state budgets, if this is not an opportune time for reform on this scale, Connecticut should not pursue it.

We are still hopeful that our input will be included, a more thoughtful reform process can begin, and we will be working constructively with policymakers to make responsible health reform in Connecticut a reality.

Respectfully,

Ellen Andrews, PhD
Executive Director
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Consumer under-treatment protections language
In Value-Based Payment Strategy Section of Draft 1.0
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 improve.