Connecticut's final SIM plan: Consumer advocate questions 1.0

Connecticut's executive branch policymakers have finished the State Innovation Model (SIM) plan to fundamentally transform our state's fragmented health care system – both how care is delivered by doctors, hospitals and other providers, and how it is paid for. SIM is meant to cover at least three million state residents – Medicare, Medicaid, employer benefits and private insurance – within five years. The SIM results from a federal grant opportunity to develop a plan to restructure our state's health system. Advocates and others have sent letters and public comments raising concerns about transparency, lack of stakeholder engagement, payment incentives that could create incentives to deny needed care, and new medical home standards.

Based on the final plan, independent advocates representing Connecticut health care consumers have drafted initial questions about the SIM plan and how leaders intend to implement it.

- The SIM plan is silent on downside risk in Medicaid and statements about how and when upside-only risk will be implemented are confusing. Please clarify your plans for Medicaid – specifically:
    - Is there a commitment not to implement **any** risk-based payment models in Medicaid until meaningful underservice metrics and monitoring are agreed to in a transparent, inclusive consensus process?
    - Is there a commitment not to implement downside risk in Medicaid, at least during the five year period of the proposed grant?
- We are grateful that on p. 96 the plan is clear that you do not propose eliminating fee-for-service provider payments, which will remain the foundation for payment reform. To clarify -- is this a commitment not to propose provider capitation models (which is inherently inconsistent with fee for service)?
- We are grateful that the final plan includes a commitment to deny value-based payments to providers who have demonstrated systemic under-service. However the advocates strongly urged that the system of monitoring for under-service be in place BEFORE value-based service models are implemented for **all** payers, to ensure people are protected from incentives to withhold needed care. Can you describe your timeline and process to develop the monitoring and enforcement system?
- Given recently described concerns about the impact of CT ACOs on critical community providers, will you include the impact on safety net and essential

community providers in your evaluation of the program? Will you consider contracting requirements and/or benchmarking for AMHs to protect consumer access and choice of providers similar to HUSKY HMO and insurance exchange QHP requirements?

- Are your plans to create Prevention Service Centers meant to supplant current funding sources or to represent new funding and preserve the current level and diversity of options for consumers to choose among for those services?
    - This raises significant concerns of shifting decision-making about support for community-based public health services from public health authorities to medical practices that are guided by different models of care. The success of many public health programs is precisely because they approach issues from an alternative perspective to the medical model. CT's health landscape is richer for having both perspectives. If the shift you have outlined in the SIM plan is meant to solve the problem of linkage between CT's public health and medical care sectors, there are less disruptive ways to do that.
    - If this is meant to replace or shift the landscape of existing programs and consumer choice -- leaving the choice of which programs survive up to medical practices and ACOs could be problematic. We are concerned about financial and/or corporate ties defining choices available to consumers.
    - If this is meant as new funding, will there be mechanisms to share information (2-way communication) between those non-contracted programs and AMHs for consumers who choose a preventive care program that is not contracted with their ACO or AMH?
- Your community health section states an intention to engage and empower communities in priority setting but sets specific priorities for the entire state – tobacco use, obesity, and diabetes. While many CT communities have identified these in local, community-driven initiatives, some have focused on other issues. Will there be an opportunity for communities to modify and/or change the SIM-determined priorities?
- Please give us more detail on AMH standard setting? Is there a commitment to ensure that it will be at least as rigorous as the well-established and widely-accepted NCQA standard for PCMHs, which (with the glide path option) has been successfully deployed in the Medicaid program? The plan notes some potential extra requirements but nothing references **easing** some requirements that providers have complained about. What are those standards you intend to drop? Who will decide on AMH standards and will providers possibly subject to those standards recuse themselves from voting?

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