Connecticut Health Policy Project

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Comments on SIM Preliminary Issue Briefs #1, #2 -- March 24, 2014

Preliminary Issue Brief #1 – Care Experience Surveys

It is critical that patient experience survey results are used to their full potential to improve the quality of care. It is recommended that

- That SIM aggregate survey results across payers
- As soon as possible, validated survey results be made public, by practice, to help consumers choose the best care for their needs
- Document how plans and public programs are using results to improve care and reward higher performance
- Ensure that feedback to providers on patient experience is constructive and followed with targeted, appropriate assistance and tools to improve performance

Preliminary Issue Brief #2 – Financing New Services and Activities

The intention of policy proposal b) is unclear. Is the intention to:

- Net out advanced payments for new services such as care coordination, medication management, and community-delivered prevention services from shared savings?
    - This is troubling because these new services are expected to provide value, with increasing evidence demonstrating that contention
    - The costs of other types of new, more effective drugs or treatments that are expected to add value are not netted out of shared savings. On the contrary, they are encouraged in value-based designs through lower cost sharing and provider incentives
    - These new proposed services described in Brief # 2 may be a different form of "treatment" but they are no less effective and will improve value
    - There should be no disincentive to providers to provide them, as a reduction in shared savings would be

- Or is the proposal's intention to eventually eliminate advanced payments for new services and replace them with shared savings
    - This is even more troubling as it would create an overly strong incentive to achieve shared savings for providers who have invested in care coordination and other new, unreimbursed services to recoup their investment
    - This proposal is similar to downside risk in that it puts providers at risk for losses

- This proposal also adds more uncertainty for providers into an already uncertain payment scheme.
- What remaining risk will "payers" assume under this proposal? What is their role/what value to they add to the system?
- In contrast to a general advanced payment for new, more efficient services which promotes holistic, population-based improvements in health, this proposal would incentivize providers to parse their panels. The incentives would encourage providing those new resources not to all patients who would do better and become healthier, but directing them to patients that will achieve savings that exceed the cost of the new services.
- While it is true that Medicare doesn't include advanced payments in their ACOs, the program does account for the costs of many of the SIM new services in the calculations that serve as the foundation for provider fees. The paper points out that Medicare does pay advanced payments in the Comprehensive Primary Care Initiative – because of the network structure. In fact, that structure is very similar to what networks in Connecticut are likely to look like in the near future – loose groups of small, unaffiliated practices. This proposal could interfere with Connecticut's market and there is no evidence that encouraging larger groups will improve value – in fact, there is mounting evidence to the contrary.

- As to the concern that small IPAs and others cannot afford to pay advanced payments out of pocket – that is not a reason not to do the right thing – it is a reason to find another way. Advocates lots of ideas on that.

April 4, 2014