Update: FAQs

What is SIM and why should advocates/legislators care?

What is SIM?

The State Innovation Model (SIM), also called the Connecticut Healthcare Innovation Plan, is the administration's plan to fundamentally transform our state's broken health care system – both how care is delivered by doctors, hospitals and other providers, and how it is paid for. Connecticut spends about $40 billion on health care each 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 last year we received a $3 million federal grant. The state used the grant to hire outside consultants and new state employees, across agencies and UConn. 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 is competing 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 SIM final plan was developed by a new state agency advised by a steering committee, that still exists, and three workgroups, which no longer exist. Seventy percent of the original SIM steering committee members are from state agencies; other members included two insurers, two foundations, a doctor and a large company. Consumers, hospitals, legislators and legislative staff were not represented. Recently the steering committee has added some consumer advocates and more providers. The original workgroups met over just a few weeks last summer. Meeting notices were buried on the website of a defunct state office. Meetings were held, often in the evenings, in out-of-the-way office buildings.

The administration-appointed steering committee approved the final plan drafted by staff and outside consultants, with only one notable change; a condition,

promoted strongly by consumer advocates, on financial incentives to protect people from inappropriate stinting on care (see below). There has been no legislative input into SIM.

What is in the 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, Connecticut-only medical home certification standards bypassing national accrediting bodies like NCQA and JCAHO. The development and implementation of the new Connecticut-specific PCMH standards, and technical assistance for practices to achieve it, will be under the authority of a new, small state agency. There are currently over a thousand NCQA certified PCMH providers in Connecticut[ii] and the list grows every month.

The proposed payment model, shared savings[iii], places financial control of patient care on those medical home providers. Shared savings 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. To qualify for savings, providers must be approved as PCMHs under the new Connecticut-specific standard. It is unclear how, or even if, PCMHs will be exempted from losses that are beyond their control, such as hospital or specialty care expenses. This payment model is very new; sophisticated groups in other states are struggling to make it work.

Under the SIM model, providers will have a direct financial incentive to control costs. 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. Expectations for patients' costs to calculate shared savings will be risk adjusted to allow for varying patient needs. 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. In a last minute addition to the SIM final plan, providers who are found to have denied appropriate care will be denied incentive payments generated by denying that care.

The math and the assumptions to develop those shared savings cost level expectations and risk adjustments are complex and controversial. That area of health finance is still developing.

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

So what is happening now?

SIM is convening new workgroups and hiring consultants to implement the plan and apply for the larger federal grant. The workgroups include some consumers and advocates, but do not address the financial model, which is being developed by staff. The scope of the workgroups is still unclear. The workgroups are purely advisory.

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 similar payment models 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]. Capitation is a model with similar incentives to shared savings, rewarding lowering the cost of care for people. 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 the previous financing model only 57% of HUSKY children got check ups and most of them were not complete and a 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 the capitated financial model[ix].

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 consumer 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?

Independent advocates have sent letters with our concerns[x] to SIM leaders (see links below). 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 shared savings is new and that more sophisticated and mature programs in other states are struggling.

Concerns with the payment model focus on questions about the system's capacity to protect consumers' health. Shared savings 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 similar incentive 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 shared savings incentives ***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. One of the proposed workgroups is tasked with, among other things, developing this monitoring system. That workgroup has not met.

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 changes to provider financial incentives at this point is inviting unintended consequences.

Who benefits? Who is at risk?

State government will be the main beneficiary of a large federal grant allowing hiring more consultants and state employees. Stakeholders that stand to benefit from shared savings 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, and, while they must share some savings with providers, they will keep the majority of the savings generated by providers according to SIM modeling. Government, employers and other payers benefit by incentivizing providers to do the hard work of lowering costs and by moderating their own risks and costs.

Consumers and taxpayers, however, could lose significantly under shared savings. Currently when advocating with an insurer to cover necessary treatments, patients generally have providers on their side. Under shared savings, we will be making our

plea to providers, and the cost of care could come out of that provider's bottom line. In fact, patients may never hear about costly but effective treatment options from providers under the SIM 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 advanced analytics and performance/quality monitoring to create local solutions. 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 also have strong data analytic capabilities they are using to target quality and access interventions. They have a large, diverse, public stakeholder group, including advocates and consumers, that meets monthly. Colorado has a strong stakeholder and public input process. 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 shared savings, rolling out along a pre-set timeline with at least 80% of state residents in a shared savings 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, Connecticut is 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. A diverse workgroup is now developing an underservice monitoring system for health neighborhoods in an open process. 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 payment reform happening now? Shouldn't we get ahead of it?

Yes and no. Shared savings arrangements are just beginning to creep up in provider contracts in Connecticut. It is estimated that 8% of Connecticut residents are currently covered by a health plan that includes some shared savings incentives.[xi] The best information from Connecticut medical/professional societies and providers is that a few large provider groups are testing shared savings, that shared savings is rare in our state, and that it covers a very small number of consumers.[xii] We are far behind neighboring states in these arrangements. We can wait to see if shared savings is successful or not and benefit from others' experience.

What can advocates do to fix SIM?

Advocates can reach out to policymakers, especially Lt. Governor Nancy Wyman, legislators, and the media, echoing concerns raised in the advocates' letters to SIM leaders:

- Engage consumers and advocates in the SIM process immediately and in meaningful numbers
- Focus on building a robust quality monitoring system that must be in place and functioning ***before*** any provider incentive dollars attach, and
- Re-open the SIM payment model decision, working in an inclusive, transparent discussion, toward a consensus payment model that is workable for Connecticut and protects consumers
    - Continue to use nationally recognized PCMH standards that are based on research and best practices such as NCQA

You can join the growing list of consumer advocates working on this issue by emailing andrews@cthealthpolicy.org.

What can legislators do to fix SIM?

- Call or send a letter to the Governor and/or Lt. Governor urging them to
    - Engage consumers, advocates and legislators in the SIM process immediately in a meaningful way,
    - Focus on building a robust quality monitoring system that must be in place and functioning ***before*** any provider incentive dollars attach, and
    - Re-open the SIM payment model decision, working in an inclusive, transparent discussion, toward a consensus payment model that is workable for Connecticut and protects consumers
    - Continue to use nationally recognized PCMH standards that are based on research and best practices such as NCQA
- Write an Op-Ed, column and/or speak to the media
- Support legislation to create a meaningful quality council, similar to other states, to build a robust quality improvement and monitoring system for Connecticut, foster the development and adoption of quality improvement innovations for providers and consumers, and develop effective patient resources to improve quality and appropriate care
    - The council must be independent of SIM, reporting to the General Assembly, and include all stakeholders with experts in quality measurement and accountability
- Support open government legislation to ensure that future health care reform planning in Connecticut is transparent, includes all stakeholder voices, emphasizes quality, and is subject to legislative review

Links

Advocates' responses to SIM policy briefs
Policy Brief #1
Policy Brief #2
Policy Brief #3
Policy Brief #4

Independent Advocates' SIM Concerns – underservice language

Independent advocates SIM concerns 3.0

Answers to advocates' SIM questions

Summary of SIM public comments on final plan

CT Health Policy Project SIM comments final plan

Independent consumer advocates SIM concerns 2.0

CT's SIM plan – pros and cons

Independent consumer advocates SIM guiding principles

Independent advocates SIM concerns 1.0

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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] Leavitt Partners, 1/2/14
[xii] ibid