



Update: FAQs

## **What is SIM and why should advocates and 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<sup>i</sup>, 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 to date.

### **What is in the SIM plan?**

The SIM plan includes expanding medical homes, and putting providers at financial risk through a shared savings payment model. It includes improvements in public health and a controversial change to Medicaid financing. The SIM plan is to have over 3.1 million state residents covered by a shared savings payment model by 2020.

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. It is unclear how, or even if, providers 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.

These incentives are very similar to the failed HUSKY managed care capitation model, but are arguably more dangerous as the rewards go to the providers who are in a very dominant position to reduce levels of care. Advocates are especially concerned about shared savings for Medicaid members, a traditionally under-served population.

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.

The SIM plan relies on transforming medical practices to coordinate care and accept financial risk. They changed the name of the successful person/patient-centered medical home (PCMH) model to advanced medical homes. After much lobbying they abandoned an ill-conceived plan to create CT-specific PCMH standards and will continue to use the well-tested, proven successful national NCQA standards. While

PCMHs in Connecticut are growing, there are many practices that have yet to meet NCQA standards of quality and access. Unfortunately in a very late decision, well after the plan was finalized in December, SIM resources that were planned to help more practices achieve PCMH certification, those resources were diverted to support Medicaid shared savings.

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.

### **What’s the plan for Medicaid?**

Advocates are concerned that the new Medicaid plans are not well considered and could result in a return to failed managed care policies of the past. Medicaid has enjoyed significant improvements in quality and access to care, more participating providers and lower per person costs since the state moved away from the failed capitated managed care structure. In a large change from commitments in the December final plan, over just a few week period SIM leaders made titanic changes to Medicaid plans. Originally Medicaid reforms would begin with the consensus, well-designed health neighborhood pilot of coordinated care for people eligible for both Medicare and Medicaid. The Health Neighborhood pilot pre-dated SIM by over a year, enjoys wide support across stakeholder groups, and was designed with an iterative, transparent, inclusive process that engaged all stakeholders. The plan was to continue implementation of health neighborhoods, learn what works and fix what doesn’t, monitor the rest of Connecticut’s market, and only then consider further payment reforms for other Medicaid populations. In the meantime, Medicaid would continue to expand current reforms that are showing great promise.

A few weeks before the grant application was due, without warning or consulting stakeholders, SIM leaders changed course. They now intend to move over 200,000 Medicaid members into shared savings payment arrangements in January 2016, and two more waves of at least 200,000 in two year increments. Very few details of the new plan have been shared, or even exist, to support this shift. Policymakers made it clear that the shift to shared savings was precipitated by a belief that it was necessary to win the larger SIM grant for state agency and consultant funding.

### **So what is happening now?**

The SIM Test Grant application was submitted in July. SIM is convening new workgroups and hiring consultants to implement the plan. Going forward, SIM has committed to more transparency and engaging stakeholders. They have created new workgroups which are in varying stages of development. 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 moving forward. SIM leaders are not open to changing 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<sup>ii</sup> and improving access to care<sup>iii</sup>. 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<sup>iv</sup> and provider lists were not accurate.<sup>v</sup> 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<sup>vi</sup>. Progress toward improving those rates actually slowed when Connecticut instituted the capitated financial model<sup>vii</sup>.

### **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 several letters with our concerns<sup>viii</sup> 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 just begun to meet.

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, especially large institutions and groups, could benefit by gaining control over their practices, over patient care, and potentially substantial financial rewards by lowering the cost of caring for their patients. However, providers will share in only some of the resulting savings and could take on more liability for lower levels of care. 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 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.

The Health Neighborhood pilot builds on this success. 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.<sup>ix</sup> 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.<sup>x</sup> 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 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 practice transformation resources to build more NCQA certified PCMHs and improve access to high quality care across our state
- 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

[Independent advocates concerns about new SIM Medicaid proposal](#)

[Questions on new SIM Medicaid proposal](#)

[Public comment on new SIM Medicaid plan](#)

CT News Junkie Op-Ed – [Connecticut shouldn't revert back to failed Medicaid policies](#)

[Why national standards for medical homes matter for Connecticut](#)

[Webinar: The value of NCQA recognition of patient-centered medical homes](#)

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 News Junkie Op-Ed – [Connecticut needs to prioritize quality and open health redesign process](#)

[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 [HUSKY B saves \\$4 million in Switch from HUSKY HMOs](#), Dec. 2012
- iii [Early results on CT's state employee wellness program encouraging](#), Feb. 2013
- iv [Comptroller's audit finds \\$50 million savings in DSS budget](#), May 2009
- v Mystery Shopper Project, Mercer for DSS, October 25, 2006
- vi *ibid*
- vii [Well-child care in Medicaid: How is Connecticut doing?](#), CT Health Policy Project, Nov. 2001
- viii Aug. 22 [letter to Lt. Gov. Wyman](#) from 24 consumer advocates
- ix Leavitt Partners, 1/2/14
- x *ibid*