From: Sheldon Toubman [SToubman@nhlegal.org]
Sent: Sunday, April 06, 2014 11:11 PM
To: LtGovernor Wyman; Foley, Anne; Veltri, Victoria; Michaud, Michael; Schaefer, Mark C.; FPadilla@UniversalHealthCT.org; pat@cthealth.org; Ahmed, Tamim; Pakulis, Bettye Jo; thomas.raskauskas@stvincents.org; Rehmer, Pat; ftorti@uchc.edu; Bremby, Roderick L.; Dowling, Anne Melissa; Woodruff, Thomas; jvantassel@clrp.org; Jane McNichol; s.lagarde@fhchc.org; Chaparro, Deanna L; Hopes, Daisy; Madrak, Jason; 'Brenda.Shipley@ct.gov'; WOLMAN, FREDERICKA; rmmclean@optonline.net; 'jeffrey.beadle@wrccinc.org'; Sitler, Dana; 'KGAFFORD@UCHC.EDU'; 'preston@uchc.edu'; 'dserednitsky@griffinhealth.org'; 'pcharmel@griffinhealth.org'
Subject: SIM: Independent Consumer Advocates' Position on Proposal to Impose "State of Mind" Test for Under-Service Measures
Attachments: Underservice.State.of.Mind.Test.Advocates.White.Paper.Final.4.6.14.docx

To: Members of SIM Steering Committee (Note: the above e-mail list may not be complete; e-mail addresses are not available on the SIM website)

Attached please find independent consumer advocates' position on the proposal to insert the word "intentional" or any other word or phrase as a qualifier before "failure" in this sentence of the draft charter for the Equity and Access Committee:

"Under-service refers to the ***intentional*** failure of a provider to offer necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements."

Although there was objection expressed to the word "intentional" in this proposed charter at the March 24th steering committee meeting, it was suggested that, rather than simply removing the word, some **other** word or phrase should take its place. This paper explains why the word "intentional" should be removed, why no word or phrase should take its place, and why the phrase "evidence-based" should not be added.

Thank you for your attention to this matter.

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From: Ellen Andrews [andrews@cthealthpolicy.org]
Sent: Wednesday, April 02, 2014 7:47 AM
To: Schaefer, Mark C.
Subject: question about policy paper #2

Mark,
I have some questions about your policy paper #2 on payment.

In your option b) is the intention to

1. net out advanced payments from shared savings
    a. this is troubling because these are new services expected to provide value (with increasing evidence demonstrating that contention)
    b. just like new, more effective drugs or treatments that are expected to add value (I'm not talking about the shiny new toys that are not cost effective and/or clinically any better than current treatments)
    c. the costs of these newer, more effective drugs and treatments are not netted out of shared savings
    d. these new services may be a different form of "treatment" but they are no less effective in promoting health
    e. there should be no disincentive to providers to provide them (as a reduction in shared savings would be)
2. Or – do you mean to completely stop advanced payments for care coordination, etc. and replace them with shared savings
    a. Really really bad idea
    b. This makes the need to achieve shared savings very coercive to providers who have invested in care coordination and other new, unreimbursed services to recoup their investment
    c. It is similar to downside risk in that regard, it puts providers at risk for losses
    d. It adds more uncertainty for providers into an already uncertain payment scheme
    e. What is the role of so-called "payers" if they abdicate even this final bit of risk – what value do they possibly add in this scenario?
    f. In contrast to a general advanced payment which promotes holistic, population-based improvements in care/health for everyone, this would incentivize providers to parse their panels – only providing effective care to the ones they believe (with very little ability to predict – the science is just not there) will cost less – not do better, become healthier – but just the ones they can save money on (hopefully it goes without saying that those are not the same thing)
    g. While it is true that Medicare doesn't include advanced payments in its ACOs, it does account for many of the services you described in their time calculations that serve as the foundation for provider fees. You point out that Medicare does pay advanced payments in the primary care initiative – because of the network structure. In fact, that structure is very similar to what networks in CT will look like in the near future – loose groups of many small unaffiliated practices. Not to recognize and support this is interfering with CT's market – and there is no evidence that encouraging larger groups will improve value – in fact, there is mounting evidence to the contrary.
3. 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. I have lots of ideas on that.

The advocates will be sending more formal comments (whether or not you want it) and it will be released publicly. But I think you can see how I will be urging my colleagues to respond.

To be clear, our comments may not be released before your meeting. As we are not at the table, we have no obligation to inform the process and have no assurance we will be listened to in any event. We may choose to wait and comment on the group's decision publicly. As I told you earlier, we were very disappointed by the dismissive response to our last letter. Many of us had been trying to work toward a more collaborative, respectful strategy.

If you'd like to talk about any of this, give me a call.
Ellen

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