INDEPENDENT CONSUMER ADVOCATES' POSITION ON PROPOSAL TO WATER DOWN SIM UNDER-SERVICE MEASURES WITH TEST OF "INTENTIONAL" CONDUCT

At the March 24, 2014 meeting of the SIM Steering Committee, various suggested charters for its advisory councils were presented. As a couple of members pointed out, one of the proposed charters was particularly troubling: the one concerning the Equity and Access Council. Specifically, it included the statement that:

> 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. (emphasis added).

The use of the word "intentional" **or any other word or phrase related to state of mind** must be excluded from this definition and charter, because any such test is inconsistent with the entire premise of the SIM proposal, would render any under-service measures unworkable, and would also violate the terms of the SIM plan submitted to CMS in December, 2013.

Under the SIM plan, under-service measures must be developed by the Equity and Access Council, poor performance on which will result in no shared savings. The under-service measures are particularly important, distinct from the quality measures which are going to be developed by the Quality Council, because they are essential for preventing harm to patients. While the aspiration is that SIM will **improve** quality as well as save money, no one really can say if that will happen; on the other hand, putting financial risk on providers, as under shared savings, could well **harm** patients (even if, or because, the implementation of the plan is saving money), at the same time that their providers manage to do well on quality measures through "teaching for the test". Clear, objective under-service measures are essential to prevent that harm.

Specifically, on page 100 of the SIM plan submitted to CMS, it states:

> The task of this Council will be to examine to what extent under-service is likely to occur under value based payment methods, recommend methods that will help guard against these risks, and urge payers to adopt such methods on or before implementation. *Practitioners who participate in our new model and are determined to have achieved savings through systematic under-service, will not receive shared savings*. (emphasis added).

Critically, there was no word "intentional" or any other word concerning state of mind included before the phrase "systematic underservice." There is a very good reason for this: The proponents of SIM regularly state that doctors are over-prescribing and over-providing because of the inherent financial incentives of the "fee for service" system under which they get paid for volume, and they also state that this usually occurs not because of any intentional practice but because of the inherent nature of financial incentives. These incentives often influence doctors and other providers to over-prescribe in subtle ways, i.e., it is a largely unconscious process in the complex area of medical prescribing. Each day, many doctors make hundreds of decisions about treatment and diagnosis, and all of the thinking behind those decisions can be influenced by a variety of things obvious, subtle and unconscious. But as noted in the plan:

> As Connecticut pursues a shared savings program, we anticipate that focusing payment on value with quality performance requirements will lessen the likelihood of both under-service and over-service. Still, there is the possibility that some providers might seek *savings through under-service, just as the fee for service system encourages over-service.* Pages 99-100 (emphasis added).

There is no basis for applying **any** state of mind test to any of the under-service measures, just as no such test is applied in the SIM plan's fundamental assumption that over-prescribing is rampant under the financial incentives of fee for service.

In addition, any test of intentionality or state of mind would render the under-service measures useless as a means to protect against harm from health care withheld; shared savings could not be withheld absent **proof** of intentional, reckless or negligent under-service. This very high burden of proof could be interpreted as requiring something similar to a full-blown trial where the SIM administration would have to try to prove the state of mind of the provider. Knowing that this would in practice never occur, providers would know that, as a practical matter, any under-service measures which have the word "intentional" or any other state of mind word or phrase tied to them would never be enforced -- even if the conduct **were** intentional. This would completely undermine the whole purpose of the Equity and Access Council developing under-service measures.

Lastly, any use of an "intention" or other state of mind test would contradict the SIM plan submitted to CMS. There is already substantial controversy with the plan, but at least the statement of under-service measures not including any state of mind test is clear. It will unnecessarily raise further issues and controversy if the Steering Committee attempts to rewrite that statement now.

In sum, any under-service measures must be objective and not be dependent in any way on the intentions or other state of mind of the provider who has obtained savings. Although it was suggested at the March 24th SIM Steering Committee meeting, after some discussion, that the word "intentional" should come out of the charter and that some **other** word or phrase should take its place, the word should be removed entirely and no qualification language of any kind should take its place. Rather, as stated in the official plan, the denial of savings under such measures will be applied to any provider who has "achieved savings through systematic under-service," regardless of the (unprovable) state of mind of the provider who obtained them.[1]

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[1] It also was suggested at the March 24th meeting that the phrase "evidence-based" should be placed before "necessary services" in the Equity and Access Council's charter, as follows: "Under-service refers to the intentional failure of a provider to offer ***evidence-based*** necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements." (emphasis added). This is an unwarranted proposed change because much of medicine, unfortunately, is not "evidence-based," as much as we would like it to be. Requiring that the measures to be developed by the council be "evidence-based" would be too restrictive. It would also put the charge of the council in conflict with the state statutory definition of medical necessity for Medicaid, Conn. Gen. Stat. § 17b-259b(a), which fully recognizes that there are many appropriate and necessary kinds of treatment which are and should be provided even though they do not rise to the preferred level of "evidence-based" services. The same is recognized in the commercial statutory definition of medical necessity, Conn. Gen. Stat. § 38a-482a.