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Subject:	Independent Consumer Advocates' Responses to SIM Issue Briefs ## 1, 2, 3, 4
Attachments:	IssueBrief# 1.Provider.Surveys.Independent.Consumer.Advocates.White.Paper.Final.4.22.14.docx; Issue.Brief#2.Financing.Indep.Consumer.Advocates.White.Paper.Final.4.22.14.docx; Issue.Brief#3.Glide.Path.Admin.Indep.Consumer.Advocates.White.Paper.Final.4.22.14.docx; Issue.Brief# 4.Community.Integration.Indep.Consumer.Advocates.White.Paper.Final.4.22.14.docx; Underservice.State.of.Mind.Test.Advocates.White.Paper.Final.4.4.14.docx

To: Members of the SIM Steering Committee

In conjunction with the SIM Steering Committee meeting on 4/24, and on behalf of a coalition of independent consumer advocates, attached are their responses to various SIM issue briefs issued in the last few days, beyond their position paper opposing any qualifier to the term "under-service" in the mission statement for the Equity and Access Committee (copy also attached for convenience). As explained in these short responses, we have some significant concerns, as follows:

- Regarding Issue Brief #1 (provider surveys), we note that the results of consumer experience of care surveys should be made public to use as tools for choosing care and as a lever to improve care quality, SIM must ensure that results of surveys are used constructively within practices to address gaps, and SIM should provide practices with low scores assistance to improve patient experience of care.

- Regarding Issue Brief #2 (payment), we are very concerned with proposed options ##b and c which would seriously undermine the quality goals of SIM by assuring no payment to providers for care coordination and other important care management services beyond 18 months, despite strong evidence that these value-added services significantly improve the quality and efficiency of care, regardless of whether shared savings are produced.

- Regarding Issue Brief # 3 (glade path administration), we are very concerned both with the consolidation of administration in one new entity, and with the assumption underlying that proposal: that the successful patient-centered medical homes model based on NCQA accreditation, performing very well in CT's Medicaid program and generally accepted throughout the health care delivery system as the appropriate certification standard, should be abandoned in favor of some new, as-yet-to-be-developed standard.

- Regarding Issue Brief # 4 (community integration), while we generally agree with the proposal, we are concerned with the assumption that a move to much greater consolidation among providers is both inevitable and should be facilitated, when the evidence is mixed about whether such consolidation improves quality or controls costs.

Thank you for reviewing these responses. Please let us know if you have any questions.

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INDEPENDENT CONSUMER ADVOCATES' POSITION ON SIM ISSUE BRIEF #1- CARE EXPERIENCE SURVEYS

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

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

INDEPENDENT CONSUMER ADVOCATES' POSITION ON SIM ISSUE BRIEF #2- FINANCING NEW SERVICES AND ACTIVITIES

Independent consumer advocates have reviewed the revised issue brief #2, dated April 17, 2014, concerning financing of new services and activities. While we appreciate that it has now been clarified what the intentions are, we are gravely concerned about options ##b and c in this issue brief. Specifically, under option #b, payment by payers to providers for care coordination and extra services will be phased out after18 months and any payment for these important services will be provided, if at all, only as a portion of shared savings payments: "Under this scenario, if the new services or activities do not generate sustainable value (i.e., savings), *the advance payment enhancement would cease and so would the service or activity*." (emphasis added). Option #c is the same except that the payments during the first 18 months would come from test grant funds.

Care coordination services and the additional services identified, such as medication management, bring value to health care delivery enhancing quality, and increasing evidence demonstrates this to be the case. A foundational principle of the SIM plan, we had been told, was to encourage meaningful care coordination as a good in and of itself, since quality will be enhanced whether or not money is saved.

But it is clear from revised issue brief #2 that the intention, after 18 months, is to subtract from any shared savings a provider would otherwise receive the amount that would be paid for care coordination, medication management and other valuable services, and to not provide **any** payment at all for these services if shared savings do not materialize. This creates an extremely troubling financing scheme in that providers, aware that the shared savings will be reduced dollar for dollar and that they will get no financial reimbursement for providing these services if there are no shared savings, will have a significant financial disincentive to provide these important services and, where they do provide them, to over-emphasize the production of shared savings in the provision of health care.

In the issue brief, under option #b, "sustainable value" is directly equated with "savings." This is highly misleading. With the little that we know about the complexity of how savings are reached within the health care system, and what exactly they do when "shared," using such a limited timeframe (18 months) and making conclusive statements about what activities generate value and which ones do not is not good policy, even if we were only looking at saving money-- never mind when considering the more accurate and far-reaching term "value" used in the SIM plan.

Even if the new advanced services are cost effective and create value, their effect may be outweighed by external cost drivers, unrelated to the new services, and overall shared savings may not be achieved. In that case, providers will be disadvantaged financially for making investments in effective new services for unrelated reasons. This is counter-productive to the intention of SIM to stimulate investment in innovations that add value.

Medical homes have successfully been developed in recent years based on the broadly-shared assumption that you have to reimburse providers, generally on a PMPM basis, for providing quality care

coordination services—i.e., that this cannot be done on the cheap—and payers have accordingly generally agreed to pay a modest extra amount for these value-added services. This includes under the highly successful person-centered medical home program under Medicaid. The proposal to disregard this well-established policy and deny any payment at all for these valuable services if there are no shared savings generated is highly problematic.

Many providers will be dis-incentivized to make the significant investment in care coordination systems-- including hiring of care coordinators, purchasing electronic medical records, and developing a system of follow-up with patients -- not knowing if the investment will ever be recouped. And for those providers who do make the investment in care coordination and other new services, it will create an overly strong incentive to achieve shared savings, so as to recoup their investment. In this sense, it is like the very troubling concept of downside risk which has been rejected for the Medicaid program under SIM precisely because a provider, threatened with **losing** money if their patients turn out to be more expensive than the norm, will have additional incentive to cut corners to avoid a loss. Similarly, a provider who has invested in care coordination will be very worried about losing this investment if there are no shared savings and all payments for care coordination and other care management services come to a complete halt in 18 months. The provider will have a powerful incentive to save money by reducing access to appropriate but expensive care, so as to avoid such a loss.

Rather than ensuring advanced payments for new, more efficient care coordination and care management services so providers can provide these new resources to all patients, maximizing health, options ## b and c would encourage providing these new resources, at best, only on a highly selective basis to patients for whom it is anticipated by the provider they can achieve savings that will exceed the cost of the new services. This would violate one of the key claims set forth in the SIM plan, that quality enhancement is at least as important as cost control, and should be rejected.

Finally, the arguments made in the revised issue brief about why advance payments are problematic for some payers or providers are not persuasive. The concern that some small Independent Practice Associations (IPAs) and others cannot afford to pay advance payments is not a reason not to do the right thing here; it is a reason to find another way to provide those payments, such as through the grant payments already contemplated in option #c (for 18 months), for all five years or until the IPA is able to take this on. And the fact that "some health plans would also like to avoid the administrative burden of managing advance payments" should be irrelevant; the idea of SIM is to design a system that can work, not to simply endorse whatever administrative changes are desired by health plans for their own convenience.

In sum, we urge the SIM Steering Committee to adopt some form of option #a in the revised issue brief, with advance payments for care coordination and other value-added services continuing for the full grant period, in recognition of their value to quality enhancement, independent of whether money is saved in the provision of health care. Alternatively, some form of option #d would be appropriate, with providers paid on a fee for service basis for extra services, as long as global care coordination is paid for on a per member per month basis, since this has become the accepted way of paying for this coordination in light of the many kinds of non-office visit tasks, e.g, telephone and e-mail,

necessary to properly coordinate care. The plan should assure advance payments for care coordination and other value-added services for the full five years, including grant payments for those few payers unable to make these payments.

INDEPENDENT CONSUMER ADVOCATES' POSITION ON SIM ISSUE BRIEF #3- GLIDE PATH ADMINISTRATION

The brief proposes to create a "glide path" program supporting practice transformation for small to mid-sized practices. The brief proposes to bring all medical home transformation under control of SIM and the very new Program Management Office (PMO) within the Office of State Healthcare Advocate. As the undefined Advanced Medical Home (AMH) certification will be a prerequisite for receiving payment incentives, this places a great deal of responsibility and authority in a single very new agency. We are very concerned both with the proposed consolidation and with the intended abandonment of the broadly-used, effective NCQA standards for Patient-Centered Medical Homes which is presumed in this proposal.This proposal to concentrate is in addition to previously described plans to reject the well-recognized, well-vetted Patient-Centered Medical Home (PCMH) certification by national accrediting bodies such as NCQA for the as-yet-undefined AMH designation specific only to CT and to SIM.[i] Over time, NCQA has been very responsive to concerns raised by providers and other stakeholders. Rather than eroding standards in response to complaints, NCQA makes thoughtful, considered, common sense improvements to the standards when appropriate. There are currently 963 recognized PCMHs in Connecticut and that number grows every month.[ii] The growing evidence of improved quality and access to care and cost control in the literature is connected to certified PCMHs. Connecticut's successful Medicaid PCMH program, demonstrating remarkable improvements in quality care and lower per person health costs, rests on NCQA certification.[iii] In setting and applying PCMH standards, NCQA can access expertise and resources that Connecticut state government cannot match.

It is unclear what benefit for any Connecticut consumers is expected from abandoning this successful model. Shifting Medicaid, particularly, from the successful model jeopardizes the hard-won progress the state has made with that program in recent years and the benefits to this growing program that serves 700,000 of CT's most fragile consumers. DSS has done well in managing this transformation, including through use of a glide path to NCQA certification. Since it is doing well, it should not be "fixed" in favor of some undefined and untested PCMH standards administered by a newly-created agency.

One reason given in Policy Brief #3 to centralize authority in the PMO is that each provider would have to apply to each payer separately to qualify for rewards. However, currently payers now virtually universally recognize NCQA accreditation so there is little to no additional administrative burden on providers. This system works very well in Medicaid and in other states.

Another problem with concentrating AMH/PCMH certification under the PMO was highlighted in the work of the SustiNet PCMH task force. The task force, convened in 2009 to develop a statewide system of support for PCMHs, was diverse in its membership and operated with full transparency.[iv] Early on, discussions focused on creating a central source for PCMH support (analogous to the proposed SIM glide path). This model was very successful in Vermont. However after much discussion it became very clear that due to cultural and corporate differences, there is no one source of support that would be acceptable to a large majority of primary care providers in our state. Based on discussions that led to endorsing NCQA as a standard, it was very clear that any single CT-based authority for PCMH

designation, no matter the stature and record of success, would not carry the credibility necessary for adoption by most payers and/or providers. It is very unlikely that a new agency would be able to overcome those challenges.

We urge SIM not to adopt the proposal outlined in policy paper #3 and to work with independent consumer advocates and others with experience in successful reform of CT's health care delivery system to find a feasible plan, based on use of the well-established NCQA PCMH standards. The success in the Medicaid program should be built upon, not abandoned.

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[i] CT SIM final plan, p. 62

[ii] NCQA Recognition Directory Search, April 21, 2014

[iii] Connecticut's Medicaid program success: Significant improvements in access, quality care and cost control, CT Health Policy Project, February 2014

[iv] Final report, SustiNet Patient Centered Medical Home Advisory Committee, July 2010

INDEPENDENT CONSUMER ADVOCATES' POSITION ON SIM ISSUE BRIEF #4- PRIMARY CARE PRACTICES AND ADVANCED GROUPS AND NETWORKS

The brief proposes using SIM grant funds to provide resources and assistance, primarily to safety net providers, for community integration of Advanced Medical Homes (AMHs) with social service partners in communities. Advocates are supportive of this concept, particularly if, as the proposal develops, SIM follows the successful example of other states such as Vermont's Blueprint for Health.

We would suggest that these resources not be limited to only small to mid-sized practices, but be available to patients of every Connecticut practice. While large practices may have the resources to integrate care with community resources, they often do not have the local connections to make that integration successful. We also suggest that the state make clear expectations that all payers will share in the costs and support for community integration.

Introductory remarks in the brief appear to make the assumption that Connecticut's health system is accelerating toward consolidation and the brief makes clear that SIM intends to facilitate that trend. This is unwise. First, there is scant evidence given of the trend. Provider practices in Connecticut are disproportionately small and have enjoyed a very independent culture historically. This contention is more consistent with corporate cultural foundations than premised on any real-world, Connecticut-based community health experience. But even if SIM's predictions are correct, it is not clear that consolidation in markets is favorable to preserving smaller practices for either quality or cost of care. Anti-trust concerns are already large and growing in Connecticut's hospital environment and national evidence on the quality or cost benefits of Accountable Care Organizations is mixed at best. It would be unwise for SIM to advocate or facilitate consolidation of Connecticut's health care system.[1]

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[1] It is important to note the difference between the benefits of integration across the system and consolidation, which involves corporate ties.

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 advisory groups 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 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 whatsoever 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 already 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.