

NEW HAVEN LEGAL ASSISTANCE ASSOCIATION, INC.

426 STATE STREET
NEW HAVEN, CONNECTICUT 06510-2018
TELEPHONE: (203) 946-4811
FAX (203) 498-9271

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CT Office of the Healthcare Advocate
Hartford, Connecticut
Attention: Victoria Veltri, Healthcare Advocate
sim@ct.gov

COMMENTS TO PROPOSED SIM PLAN DRAFT 1.1

We represent a broad range of low-income health consumers most of whom qualify, or will in January of 2014 qualify, for Medicaid. We provide these comments in response to "Draft 1.1" of the State Innovation Model (SIM) plan, as circulated November 1, 2013.

Introduction

As advocates for Connecticut's low-income health consumers, we are fully committed to the vision of redesigning our fragmented health care delivery system to promote quality care and the true coordination of all health care. We see the SIM process as an opportunity to work toward that goal, as it has been designed to do in some other states. However, the number one principle in both medicine and health policy is, or should be, to "do no harm." A treatment or policy change, no matter how well intentioned, should not be made if the net effect is to make things worse, in terms of access to care or quality of care. That is the guiding principle behind these comments, particularly as concerns the (soon to be) 700,000 most vulnerable patients in Connecticut—those on Medicaid, many of whom we represent. At the end of these comments, our few strong suggestions for the minimum protections to prevent, or at least minimize, this harm are set forth.

We support many of the findings and recommendations in the SIM draft plan. Many echo earlier work by consumer advocates and others in previous Connecticut reform reports. However, the process to develop the current SIM plan and some of the central recommendations in it are troubling. We are concerned that the process was not transparent and was developed without the participation of independent consumer advocates.¹ Almost all of the Steering Committee members who approved the plan as circulated represent, in one way or another, payers of health care, public

¹ Although two advocates not employed by the state were very recently added to the SIM Steering Committee, this was after Draft #1.1 was issued for comment. The content of that plan has been developed with no independent consumer advocates either on the Steering Committee or on the critical committee developing the payment model.

or private. As such, their primary concern, as reflected somewhat in the discussions at the meetings, and certainly in the documents produced, has quite understandably been with saving money and reducing risk for the payers, not improving care.

Not unrelated, the plan the committee approved for public comment is heavily tilted toward saving money and reducing risk for payers, with little in the way of protections for individuals who would suffer under the incentive system created by the plan. Under the specific payment model proposed for SIM, “shared savings” with providers based on the total cost of their patients’ health care, and possibly “downside risk” on providers, primary care providers, particularly those working for large employers, will be financially incentivized to restrict access to care for their own patients. We are concerned that this payment model could cause serious harm to patients by incentivizing inappropriate restrictions on access to care (a particular threat to Medicaid enrollees already suffering from lack of access to specialists).

We provide below what we believe to be the essential protections to prevent or at least minimize harm from this proposal. But first, we think it is important to address the major premises of the SIM proposal and also address the specific threats to Medicaid enrollees under the proposed payment model.

Assumptions in the Plan

The primary three assumptions driving this plan, the first of which is stated explicitly, are: (1) there is a prevalence of excessive, redundant and wasteful treatment, which is both harmful and expensive, because providers, paid on a fee for service basis, intentionally or unintentionally, over-prescribe in order to make more money; (2) if doctors have a financial incentive to reduce the cost of care for their patients, they will keep those costs down—but **only** by avoiding unnecessary, redundant or wasteful care; and (3) the only way to coordinate health care through “medical homes” is to put financial risk on the providers running these practices, through shared savings or downside risk.

Even assuming the first premise is correct, the other premises are based either on wishful thinking or on disregard for how Connecticut has actually done things **very right** in the Medicaid program. Just as the incentives to over-prescribe under fee for service are insidious, so the financial incentives to undertreat due to shared savings are insidious; primary care providers may deny or restrict access to appropriate specialists, tests, medications, home care services, medical equipment, etc., without even realizing it. More likely, primary care providers who increasingly work for large practices or hospital systems, which set policy, will feel pressure from their employers to restrict care in order to save money.

While the plan assumes that providers will inherently be motivated to restrict access only to **wasteful** care, the payment model could just as easily incentivize restrictions on appropriate care. Indeed, under shared savings, what is

most likely is that particularly **expensive** treatments will be restricted, whether or not they are excessive or wasteful, because providers or their employers will receive shared savings directly proportional to the **amount** of money saved on their patients. And, because of these incentives, providers working for employers exerting pressure to restrict such access may not even tell their patients of particularly expensive treatments which may be better for them-- such that the patient will not even know that this kind of care has been restricted, let alone that any appeal of the restrictions may be available. The plan references the risks of under-treatment under this proposed payment system, but then sharply minimizes the likelihood of this occurring ("there is the possibility that a few providers might seek savings through inappropriate methods," page 73), and, more importantly, provides no meaningful tools to combat those risks.

Lastly, the assumption that the SIM payment model is necessary in order to coordinate care is unsupported. Connecticut and the Department of Social Services are doing a very good job of coordinating care for Medicaid enrollees, who previously lacked any meaningful care coordination, through the growing patient-centered medical home program, which now covers over a third of Medicaid enrollees **without** imposing dangerous financial risk on providers. Under this successful model, primary care providers are paid fee for service for the health services they provide, but also are paid extra for those patients assigned to them in their medical homes, to compensate for care coordination services.

In addition, these providers are financially rewarded for performing well on a variety of quality measures, developed through a consensus process of practitioners in conjunction with DSS. Although many of those measures will save a lot of money, e.g., measures of ER use avoidance, follow-up appointments with patients within 7 days of hospital discharge, etc., critically, the providers' extra pay is *not* tied to any overall monetary target or savings, as under a shared savings or downside risk model.

As a result, providers in the Medicaid PCMH system are neutral on whether their patients need a referral or not—they are not paid more or less, depending upon whether they make or do not make a referral or send a patient out for a test; they coordinate care solely in terms of what is best for their patients. This is the kind of care coordination that is most likely to bring quality care, and is already doing so for Medicaid enrollees, and could be the central model for SIM. Thus, the assumption that meaningful care coordination is possible only through putting financial risk on providers, as in the current SIM model, ignores this highly successful non-risk model, which also is attracting providers to the Medicaid program after decades of inadequate provider networks.

Special Problems Confronting Low-Income Patients

The access problems created by imposing financial risk on primary care providers based on total cost of care will confront any Connecticut residents forced

into the SIM payment system. But they are particularly threatening to low income Connecticut residents, those with chronic medical conditions and Medicaid enrollees, the latter of whom already have a difficult time accessing health care services, particularly from specialists. Due to their circumstances, Medicaid enrollees also often have great difficulty in communicating with their providers about treatment options, in following up with recommended treatments, and in being able to take action if a suggested provider is not available for an appointment.

Under the payment model proposed for SIM, shared savings and possibly "downside risk" on providers, primary care providers, or the large employers they work for, will be financially incentivized to restrict access to care even further. Not only will the barriers to seeing appropriate specialists persist, but in some cases the initial referral to see the specialist will not even be made.

Need to Address Harm from the Total Cost of Care Provider Incentive Model

This kind of harm must be prevented, for all Connecticut residents, and particularly for Medicaid and other low-income enrollees. The current draft SIM plan does not commit to denying financial incentives to providers or their employers found to have generated savings at the expense of needed care for their patients, which is the only way to enforce a policy against saving money in this fashion. The plan does not include specific language suggested by the advocates and provided to SIM project leaders at their request, attached hereto, which would have specifically denied shared savings to providers who are found to have saved money in this inappropriate way (while the plan declares that shared savings **will** be denied if other, less important to access, "quality" measures are not met). In fact, the statement included on page 74 of the plan is devoid of **any** mandatory enforcement language:

We believe that it is important to establish an integrity-like function that focuses on these issues of risk avoidance and under-service, including establishing guidelines for consequences of under-service (*e.g., may* lead to discontinuation of shared savings participation or network disenrollment) (emphasis added).

Not only must such enforcement be included, but the plan must make crystal clear that the broad measures for under-service which disqualify a provider from shared savings will be fully developed by a broad stakeholder group, including meaningful representation by independent consumer advocates, **before** any change in payment methodology is implemented. Without such a clear condition, inevitably, based on past experience with other payment reforms in Connecticut, what will happen is that the shared savings payment methodology will be implemented -- with no meaningful protections in place.

Finally, the imposition of downside risk is likely to be even more threatening than shared savings. It is troubling enough that providers or their employers under shared savings may make more money by restricting access to care for their own

patients, but at least they get paid guaranteed rates for all services they provide. Under “downside risk”, however, these same providers may have to **pay back** some of the money they already earned through fee for service payments, if the payer’s savings targets are not met. This is highly likely to motivate providers to restrict access to care even further, to avoid a situation where they fail to meet a savings target and thus **lose** money.

Downside risk is a threat to access to care for all patients. But it is particularly threatening for Medicaid enrollees. As noted above, it has been a struggle to get providers into the Medicaid program. They complain, often bitterly, about the low reimbursement rates (the mandated higher rates for primary care providers under the Affordable Care Act expire on December 13, 2014). The removal of managed care organizations coupled with the development of the non-risk PCMH model starting in 2013 have helped to reverse this troubling history. But if providers learn that, not only their reimbursement rates will be low, but they may have to **pay back** some of that inadequate reimbursement already received, they are very likely to depart the program altogether in large numbers.

In recognition of these special problems, the previous SIM plan draft wisely barred downside risk in the Medicaid program. But it was put back in as an option (so long as it was not imposed at the very beginning of SIM implementation), at the request of the Office of Policy and Management, which specifically acknowledged that it desired downside risk as an option **solely** to save more money. And, it should be noted that, since Medicaid enrollees in Connecticut do not pay premiums or any other cost-sharing, such savings inure only to the benefit of the state, not to the enrollees.

These serious problems in the current SIM plan could have been avoided by adopting the successful non-risk model in the current PCMH Medicaid program. To prevent, or at least minimize, harm to Medicaid and other low-income patients from the payment model in the current SIM plan, the final plan must make a clear, unequivocal commitment that:

- Providers found to have denied or restricted access to necessary care will be prohibited from receiving shared savings or other financial rewards
 - Robust quality measures of under-treatment which are the basis for denial of shared savings, including inappropriate denials or limitations on care or avoidance of expensive patients, must be developed in an inclusive committee with significant independent consumer advocacy membership
 - The system to measure and sanction under-treatment, and a fair process to resolve disputes, will be in place **before** any provider incentives are implemented

- All decisions will be reached in a transparent, public process based on significant public input
- Independent consumer advocates will be included in meaningful numbers on all SIM committees
- As in the first SIM plan draft, downside risk payment models are excluded in the Medicaid program

If these basic protections are not adopted, the SIM plan risks doing more harm than good, and will not be in the best interests of Connecticut's over three million patients. Connecticut should not pursue a plan that lacks basic consumer protections, especially since we are already making progress independent of the SIM proposal.

We are still hopeful that our input will be included, a more broad-based reform process can begin, and we will be working constructively with policymakers to make responsible health reform in Connecticut a reality.

Thank you for your attention to these comments.

Respectfully submitted,

Sheldon V. Toubman
Staff Attorney

**Consumer under-treatment protections language
for Value-Based Payment Strategy Section of Draft 1.0**
Additions are underlined, deletions are [bracketed]

p. 57 to 58 – paragraph that begins Shared savings payment models offer a range . . .

In addition, we will adopt advanced analytics to identify outliers for underuse. To correct for incentives to generate savings at the expense of needed care, providers who are found to have inappropriately under-served patients, through denials or limitations on the amount, duration, scope, type or level of service prescribed, will be excluded from shared savings payments. In addition, as discussed in the performance management section, providers will be rewarded based on both their quality and efficiency performance.

p. 59 – bullet list under Guidelines for Payer Reward Structures
Add under second bullet (Both P4P and Shared Savings should reward both absolute performance and performance improvement)

-- Providers will not be rewarded if audits demonstrate inappropriate under-service, including through denials of care

p. 60 –

changes to second paragraph—

“As Connecticut pursues a shared savings program, there is [the possibility] concern that [a few] providers might seek savings through inappropriate means, including under-service for their patients, just as the fee for service system encourages over-service.”

changes to third paragraph—

It is critical to ensure that providers do not benefit financially from savings generated at the expense of appropriate care delivery. We believe that it is important to establish an integrity-like function that focuses on these issues of risk avoidance and under-service], including establishing guidelines for consequences of under-service (e.g. may lead to discontinuation of shared savings participation or network disenrollment)]. Providers who, based on the integrity-based functions and audits, are found to have inappropriately under-served their patients, as described above, will be disqualified from receiving shared savings incentives.

p. 60-- Delete 5th paragraph (that begins – The Equity and Access Council may also recommend . . .) and replace it with:

The Equity and Access Council will develop fair grievance, appeal and resolution processes for providers who dispute audit findings. The Council will also develop a system to provide technical assistance, enhanced monitoring, improvement plans, and other necessary support for providers and practices that need to improve.