**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.