Connecticut's SIM application is in – What happened and what is left?

The State Innovation Model (SIM), also called the Connecticut Healthcare Innovation Plan, is the administration's plan to fundamentally transform our state's broken health care system – both how care is delivered by doctors, hospitals and other providers, and how it is paid for. SIM is meant to reform health care for every state resident – all 3.5 million of us. It is driven by a federal grant opportunity of approximately $40 million for state government.

SIM has been developing for over a year making important decisions about our state's health care without important voices at the table, in a non-transparent process, and missing critical consumer protections. Concerns have been raised in five letters signed by 36 consumer advocates and other public advocacy over the course of planning.

An important concern of independent advocates was the late, rushed decision to move at least 400,000 Medicaid members into shared savings without a pilot to test options, develop best practices, identify problems and find solutions. Some of the other concerns have been reflected in SIM's design, but many concerns remain.

What is in the SIM plan?

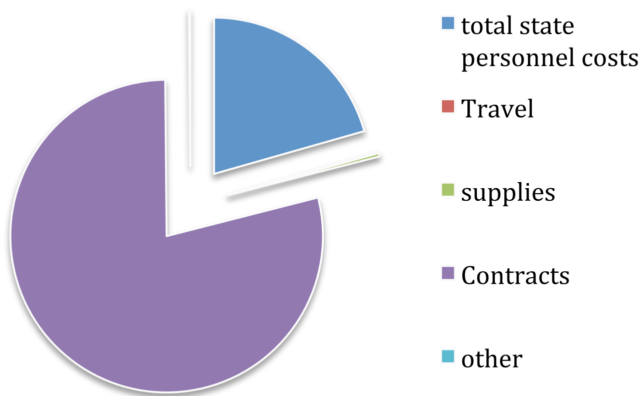
The SIM plan includes expanding and changing Connecticut's successful medical home model by putting providers at financial risk. The proposed payment model, shared savings, places financial control of patient care on providers. Very new and untested, shared savings gives providers unparalleled control over health care finances, allowing them to share in any savings they are able to generate on their own patients' health care. In response to independent consumer advocacy, SIM agreed to exclude shared savings payments that are generated by denying people necessary, appropriate care.

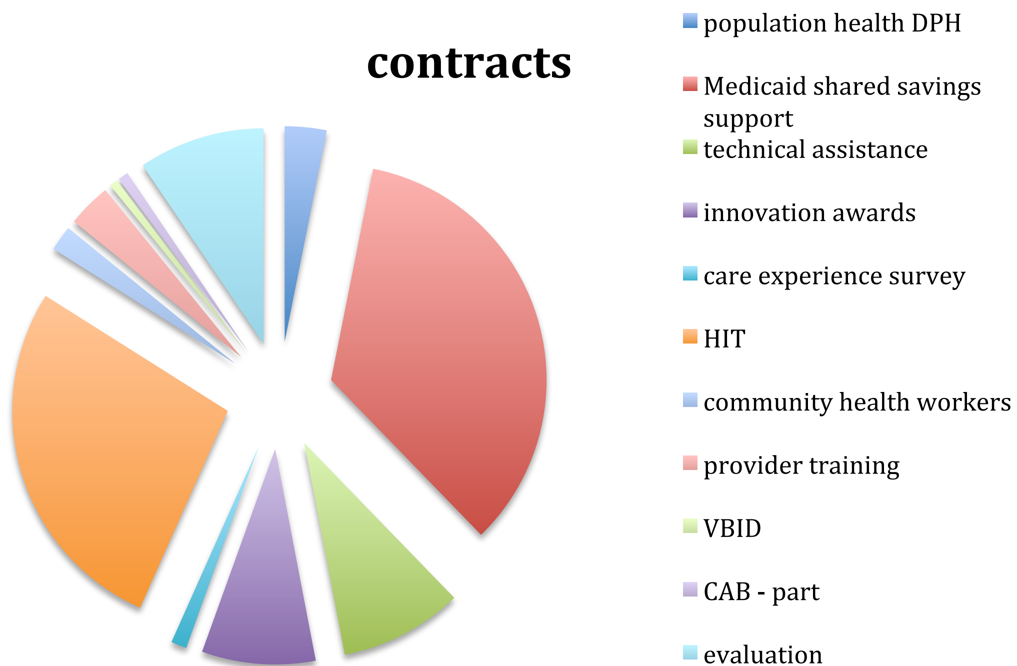
SIM quality measures and improvement plans are vague and providers must only reach "minimal" quality standards to receive shared savings financial incentives. The process to define those minimal standards and the decision-makers are yet to be defined.

SIM also includes important population health goals, for Medicaid and beyond. Three areas from the federal SIM grant application are highlighted to the exclusion of others, including important health issues identified in Connecticut needs assessments based on community input and Connecticut-specific data.

What's included in the administration's federal grant application?

The $82.7 million SIM application budget is largely devoted to adding state agency staff and hiring state contractors. The state is asking for $63.7 million in federal funds and intends to devote $19 million in state in-kind funding to the grant. 79% of the funding is devoted to contracts, mainly to support Medicaid shared savings, health information technology, and for evaluation. 21% of the budget is to hire new state employees, mainly at DSS and the Office of Healthcare Advocate/SIM Program Management Office. A great deal of the contract funding is single-sourced, especially to state entities or affiliates.





What happened to the consumer protections and best practices recommended by independent advocates?

Some of the concerns voiced by independent advocates were incorporated into the SIM plan, some were not, and others are unclear.

Issue	In the plan?	But . . .
Meaningful independent consumer representation	Not really	Advocates on committees remain a minority, too many independent advocates excluded
Deny shared savings payments for inappropriate underservice	Yes	Standards will be developed by a weak committee dominated by conflicted interests and subject to approval by even weaker steering committee, Monitoring is under-resourced in SIM budget
Underservice monitoring in place before shared savings	Medicaid – yes All other -- no	Still unclear who will set standards for Medicaid underservice
No downside risk in Medicaid	Yes	
Transparency	No	
Accountability	No	Much funding is single-sourced with no RFP, perception of conflicted interests controlling critical ombudsman and evaluation functions
Expand successful PCMH program – Medicaid and private pay	Not clear	Resources to build more PCMHs across the state diverted to support Medicaid shared savings
Honor original commitment to current Medicaid shared savings pilot first	No	Stated abrupt change was necessary to get the federal funding
At least pilot Medicaid shared savings	No	In fact, it was sped up and expanded to entire population
Use national standards for PCMHs	Yes	Redirect resources from PCMH to Medicaid shared savings supports for large practices/networks
Remove dangerous 1115 reference	Yes	Still being considered
Try bundles first	No	Never considered

What are the remaining concerns?

- Advocates are deeply concerned about the sudden policy change to an ambitious timetable shifting large numbers of Medicaid consumers into shared savings
  - There are few details about how the program will work
  - Incentives will be developed by an insular group of SIM insiders dominated by insurers and state agencies, possibly again in a non-transparent process
  - While shared savings models have great theoretical potential to improve quality and value, it is a new model with a mixed record even in more mature, better resourced states
  - Connecticut has a troubled history in Medicaid payment reform -- while progress in improving quality and care coordination in our Medicaid program has been made, there is a great deal of work to be done in building capacity for monitoring and repair before we can safely transition people into such incentives again
  - While SIM's new decision to consult with the Medical Assistance Program Oversight Council (MAPOC) is welcome news, it is critical that the integrity and independence of MAPOC not be compromised, MAPOC has a history of effectiveness and broad capacity that has benefitted Medicaid for many years, it would be a large loss to the state if that was subsumed by SIM
  - It is unclear why a SIM committee dominated by all of Connecticut's large insurers will be developing underservice standards for Medicaid consumers, as insurers no longer have a role in Connecticut's Medicaid program
  - Since our Medicaid program moved to self-insurance in an independent ASO model, quality is up, more providers are participating and per-person costs are down
  - Medicaid is a very large, unique program serving a unique population that is likely at higher risk for underservice, standards for this population should be developed by MAPOC which has the expertise and focus to ensure standards are meaningful
  - Coordination between SIM committees and MAPOC would benefit the process, but Medicaid should retain its autonomy to set standards for its members as do other payers whose choice to adopt SIM standards is purely voluntary
- Advocates remain concerned that considerable SIM resources that were previously committed to expanding the successful patient-centered medical home program to reach more state residents has been diverted to supporting the large Medicaid shared savings networks rather than supporting small practices, including those who have traditionally served Medicaid consumers, in the hard work of practice transformation

- Advocates are concerned that the payment model will not support provider investments in prevention, not all preventive services generate savings within a relevant timeframe for budgeting (some may never generate savings, but it is the right thing to do anyway), Advocates are concerned that having invested in quality improvements, including prevention, providers may not recoup sufficient savings to reimburse the expense, creating incentives for underservice
    - Providers and consumers must be confident that investments in quality improvement and prevention will be recouped
- As a very large payer offering only large networks SIM transformation resources essential to survival in evolving health systems, the new plan for Medicaid could advance market consolidation across Connecticut, driving up health costs and limiting consumer choice
- Answers to questions posed by advocates suggest that Medicaid's vision of underservice is limited to access to providers (particularly specialists) and patient experience of care surveys
    - We are concerned that this is too narrow to guide development of an effective monitoring system
    - It is entirely possible for a consumer to get an appointment with an appropriate specialist but leave with a less effective, but less expensive, prescription or treatment plan and never know they were under-served
    - It is critical to build a learning system to detect inappropriate underservice, a few metrics added to the quality list will not be sufficient, especially if the metrics are set and publicized ahead of time
    - It is equally critical to provide assistance and tools to consumers and providers to avoid and address under-service when it happens, while provider participation in Connecticut's Medicaid program is improving, we must continue to build a program that attracts and retains providers through support focused on quality improvement
- Advocates remain concerned about the undue influence of the competitive federal SIM grant process on setting Connecticut goals and strategies, including specific public health targets and quality metrics
    - Connecticut's Medicaid spending is under control, reducing even in the short term
        - Federal Medicaid and Medicare spending are a concern for the federal budget, but not for Connecticut's state budget
    - Funding for state agencies and contractors is not sufficient reason to compromise Connecticut's needs
    - Shared savings may be a laudable goal and could potentially move our health care system toward rewarding value and away from volume, but it should be implemented on terms and timetables that work for Connecticut
- Advocates remain concerned about the heavy influence of insurers on all committees, to the exclusion of independent advocates, and decision-making behind closed doors

- Advocates are concerned that critical SIM functions will be single-sourced to groups subject to conflicting interests, especially evaluation and ombudsman functions critical to consumers
- Advocates are concerned that, in the SIM proposal, consumer input and communications are expected to be funneled through a new, highly resourced Consumer Advisory Board composed of only administration appointees that has not been transparent in decision-making
- Before settling on tools such as Medicaid waivers, the state should
    - Identify health problems
    - Prioritize considering prevalence, cost, and potential to prevent or manage
    - Consider all options, identifying the most effective, both clinically and in cost, feasibility and Connecticut capacity
    - Then identify funding mechanisms, exploring all options and choosing the most narrow option that meets the identified need

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