September 10, 2015

To: SIM Program Management Office
Re: Public Comments, Underservice and Patient Selection Recommendations, SIM Equity and Access Council

We want to thank you for this opportunity to comment on the Council's Underservice and Patient Selection Recommendations. The report represents a great deal of work by a diverse committee on a very sensitive but critically important subject. The recommendations provide meaningful protections against inappropriate underservice and adverse selection for consumers entering very new, risky shared savings health care finance models. Under these models, the direct financial incentives based on reducing the total cost of care of the providers' patients could cause the providers, consciously or otherwise, to restrict access to appropriate care or avoid patients likely not to produce savings, undermining the central SIM goal of improving quality—it could actually reduce quality and make access worse for underserved populations. We urge adoption of all twenty-eight proposals, especially the single recommendation (3.5) that did not receive consensus due to resistance from only insurance industry representatives on the Council.

Shared savings models are very new and early results are mixed. Unfortunately there were no models from other states, successful or not, to guide the Council in their work. We believe this is a comprehensive, but preliminary, set of common sense policies to prevent, monitor and repair underservice and adverse selection in a shared savings payment environment. But this cannot be the final rule on this important issue. As Connecticut joins other states embarking on this experiment, we must regularly re-evaluate and revise these protections to address unforeseen hazards or tighten requirements if hazards which have been foreseen are not avoided

The consensus recommendations include very important provisions, such as full information on shared savings – risks and benefits – for consumers and providers, recognition of existing doctor-patient relationships, cost estimates based on patient needs, provider appeal rights, rewards for quality improvement, and resources to care for more challenging patients, among others. We are particularly supportive of the recommendations:

- For prospective attribution, to remove incentives to "fire" or stop making appointments for patients that may be more difficult or have conditions that are harder to treat or less lucrative in a shared savings model
- That individual providers' compensation (versus that of the ASO-like entity) not be tied, even in part, to the savings achieved on their specific patient panel, which would create an exceptionally strong incentive to underserve
- To provide rewards and incentives to improve the quality of care, independent of and in addition to any shared savings rewards. This recognizes the uncertainty

of generating savings in a complex health system and ensures providers are compensated for investments in quality
- Eliminating incentive "cliffs" that could pose an overly strong incentive to underservice
- Peer review protections for whistleblowers who uncover underservice and notify administrators
- Robust public reporting, to foster trust with transparency and accountability

We also are particularly supportive of Recommendation 3.5, which provides for shared savings payments denied to providers due to underservice or adverse selection being devoted to improving quality, rather than defaulting to insurers or other payers. Consumers are the ultimate payers of all health care – through our premiums, out of pocket costs, taxes and lost wages. We paid those funds with the expectation that we were purchasing the care we need. Savings generated at the expense of appropriate care should be returned to the original purpose – to build value – rather than remain with the insurer. Recommendation 3.5 directs the retained savings funds to an independent entity, to ensure that the funds not indirectly benefit the network that generated the underservice or adverse selection. This provision would not only reduce incentives inherent in shared savings to deny needed care, but will also provide the resources to solve the problem, and improve the quality of care across Connecticut's health care system.

Under the Council's recommendation, the insurer will still retain the other half of the inappropriately savings generated by underservice. We further suggest that State Innovation Model policymakers consider devoting **both** halves of inappropriately generated savings to building quality and remediating the problem. As insurers have powerful tools to deny, or encourage the denial of, needed care, such as prior authorization and formularies, it is important to ensure they do not profit from underservice.

We thank the Council for its hard work on this novel project and for being proactive in protecting consumers from harm in new financial models. We urge that the SIM Steering Committee and all decision-makers adopt all of its recommendations, including recommendation 3.5.

Sincerely,

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cc: SIM Steering Committee
SIM Equity and Access Council