INDEPENDENT ADVOCATES' COMMENTS TO FEBRUARY 1, 2018 DRAFT OF SIM REPORT ENTITLED "Primary Care Payment Reform – *Unlocking the Potential of Primary Care"*

I. Introduction

These comments are submitted on behalf of a broad and diverse group of independent advocates and organizations very concerned with both the recommendations of the Feb. 1, 2018 SIM-commissioned report entitled **"**Primary Care Payment Reform **–** *Unlocking the Potential of Primary Care,"* and its characterizations of what "consumer advocates" believe in relationship to those recommendations and payment reform proposals and initiatives generally. They are particularly concerned with the application of any of the proposed models contained in the report, all of which involve imposing financial risk on primary care providers, on Medicaid enrollees, and the apparent rejection of the shared savings model just now being imposed on Medicaid enrollees as **not going far enough** -- when advocates are already concerned that that "upside risk" only model already presents serious dangers to the Medicaid program and should be studied carefully before being expanded in any way. The undersigned have been, and continue to be, engaged and willing to consider and discuss payment reform that seeks to improve or enhance the quality and delivery of medical goods and services, particularly as it might affect Medicaid, and appreciate the opportunity to comment. But all of the proposals in the SIM consultants' report involve even greater threats to access to care for these enrollees than shared savings, because of the introduction of downside risk.

For the reasons set forth below, the undersigned believe that none of the three risk-based options in the report should be adopted in general and particularly for the Medicaid program, and they also reject most of the recommendations in the report, while endorsing the use of Medicaid state plan options to pay for such innovations as Community Health Workers (CHWs). They also object to the assumption that designing payment reform models for any part of the Medicaid program rests with anyone other than the Department of Social Services, with consultation and oversight by the MAPOC, whose co-chairs have already expressed grave concerns with the approach contained in this report, and its Care Management Committee.

II. The Flaw in All of The Report's Three Options

The report erroneously states that there is a broad consensus that the fee for service system must be replaced by a system whereby primary care providers take on partial or total financial risk for the total cost of their own patients' care, either partially through "bundles" or full capitation. The report fails to address the dangerous financial incentive to deny care – including office visits. The report provides no basis for the assumption that patient access will not be compromised and adverse effects such as cherry picking patients will not happen. Particularly to the extent we represent Medicaid enrollees, who are a particularly vulnerable set of patients and who already have significant access issues for certain kinds of health care and lower provider reimbursement rates, the last thing they need is for their own providers to personally lose money if their care happens to be more expensive than the norm or if they need to see the patient in person.

The three options set forth all involve imposing financial risk on providers of primary care services. While the risk of harm from this increases with each level of risk, even the lowest form, partial bundled payments whereby **65**% of the practices' annual revenue for "sick visits" is fixed on a per person basis, involves an unacceptably high risk of harm, since providers will be less likely to see patients in their offices if there is essentially no payment for doing so, unlike under the long-standing fee for service

system. As the health of the Medicaid population is generally lower than the rest of Connecticut, limits and disincentives for "sick visits" are an even greater risk.

III. Erroneous Assumptions In The Report

In order to better understand our comments opposing all three of the Options set forth in the report, it is necessary to address several erroneous assumptions made in the report which are erroneous, yet are the foundation for the report's recommendations. Each one of these assumptions is addressed below:

- Paying for primary care on a fee for service basis, even with extra payments for care coordination and with rewards for quality performance, is "unsustainable" and should be replaced.
- The replacement primary care payment model **must** involve placing financial risk on providers either under partial bundled payments or full capitation.
- The only means to pay for innovations like CHWs is through imposing risk on primary care providers.
- A risk payment model will give "flexibility" and "opportunity" for primary care providers only to innovate and never to take some or all of the money for their own increased compensation.
- This kind of financial risk should be experienced at the individual provider level.
- There is no evidence of under-service or adverse selection/cherry-picking from imposing financial risk on providers.
- Whatever risk of under-service/cherry-picking there might be from imposing financial risk would apply only for the most extreme proposals for full capitation (Options 2 and 3), and is not an issue under "Option 1" partial bundled payments.
- The shared savings model newly being imposed on Medicaid enrollees, PCMH+, is already a failure because it does not impose **enough** risk on providers, and we need to "move beyond" it to impose more risk on providers.
- Consumer advocates as a group **agree** with the SIM proponents that fee for service payment models are unsustainable, that we should transition away from it to risk-based payment models, and that any risk of harm to enrollees from imposing financial risk is worth it.

Assumption 1: Paying for primary care on a fee for service basis, even with extra payments for care coordination and with rewards for quality performance, is "unsustainable" and should be replaced.

In making the assertion that FFS payment is inherently broken and "unsustainable" because it "stimulates the provision of more services, instead of helping to fund and support new care delivery capabilities that ultimately benefit and engage patients" (page 5), and it "does not give providers flexibility to implement new processes that would help their patients," (page 14), the report fails to take into account successful payment reform models already operating in CT which **are** based on fee for service payment plus rewards for significant quality improvements. Specifically, the rigorous patient-centered medical homes (PCMH, no "+") program administered by DSS and its ASO contractor, Community Health Network, Inc., since 2012, involves payment of NCQA-accredited PCMHs in three ways: fee for service payment for primary care visits, enhanced fee for service payment to PCMHs which

have achieved NCQA accreditation (or are on the glide path to this) to cover care coordination costs for all patients accredited to them, and extra payments to reward such practices which do well on important quality measures, such as ER usage reduction. These reward payments are based on two kinds of quality measures: how practices do relative to their peers and relative to their own past performance. Combining these three forms of payments incentivizes quality of care, **not** the volume of care perceived to be incentivized by all FFS payment systems.

And, according to DSS, this FFS-based approach has had remarkable success in cost control. As DSS explained in a detailed presentation to the Medical Assistance Program Oversight Council in February, 2018, our Medicaid program far outshines programs throughout the country in both cost control and in how much of our Medicaid dollars (94.3%) go to actual health care (instead of administrative expenses). https://www.cga.ct.gov/med/council/2018/0209/20180209ATTACH_HUSKY%20Financial%20Trends%20Presentation.pdf This has all been done specifically by emphasizing primary care and the use of patient-centered medical homes to coordinate all healthcare.

Yet, not only does the report omit this successful program from its analysis (though it discusses the "PCMH+" shared savings Medicaid program, albeit as a failure), but it creates a set of categories of primary care payment under the "HCP-LAN Framework," none of which include DSS's successful non-risk PCMH program. For example, while PCMH (no +) is closest to "Category 2: FFS – Link to Quality and Value," page 15, the report rejects this model because, "while slightly better the FFS model, pay for performance models are still limited in their ability to support the addition of diverse team members," again omitting the fact that PCMH **also** includes enhanced payments specifically to provide for innovative care coordination through accredited practices.

> **Assumption 2:** The replacement primary care payment model **must** involve placing financial risk on providers either under partial bundled payments or full capitation.

Without mentioning the successful FFS-based non-risk PCMH program operating right now in CT, the report states that only putting financial risk on primary care providers through bundled payments can cure the alleged drawbacks of FFS. The SIM consultants were advised of this model by independent consumer advocates interviewed for this report. It is unfortunate and concerning that this report does not include mention of it, as it would show that this FFS-based payment system is already meeting the goals claimed by SIM, including, according to DSS, significant cost control.

> **Assumption 3:** The only means to pay for innovations like CHWs is through imposing risk on primary care providers.

The report does correctly identify community health workers as a potentially valuable innovation in care coordination. But it declares that an enhanced FFS payment model like PCMH makes it "difficult to support the hiring of alternative/diverse team members such as CHWs." In making this claim, it ignores the enhanced payments to PCMHs under DSS's PCMH program which compensate primary care practices for such innovations. But beyond this, if there was a desire to incentivize the hiring of CHWs directly, this is readily available through DSS choosing a state plan option which would allow direct reimbursement from the federal government for expenditures made by DSS to PCMHs to incentivize their hiring. This also allows state oversight to ensure that CHWs are being paid to improve effective care, and not to lower costs or cherry-pick patents to improve practices' finances. Since CHWs are reimbursable on a FFS basis, there is no reason DSS cannot do this now, under the existing successful

PCMH program which is founded on a FFS payment system. In the absence of the imposition of a provider risk model, the state would then enjoy all of the savings from CHWs hired directly via Medicaid, providing even more relief to the state budget.

> **Assumption 4:** A risk payment model will give "flexibility" and "opportunity" for primary care providers only to innovate and never to take some or all of the money for their own increased compensation.

Throughout the report, it takes on faith that imposing a risk-based payment model on primary care providers will "***allow*** providers to develop care delivery capabilities that benefit patients" and "[t]he flexibility afforded by these payment arrangements ***can*** lead to improved access" because providers "***can*** use the additional revenue to invest in innovative patient engagement and support services…," like telemedicine. But it ignores the fact that practices must, under these models, pay out of pocket for any services provided, whether telemedicine or an office visit. "Flexibility" to pay for something out of your own pocket is always present— indeed, practices have the "flexibility" now to pay for telemedicine out of their pockets. The **assumption** that practices will do this is just that.

Practices can instead take the difference between their capitated payments and how much they spend on patient care to simply increase their incomes or fill budget holes. While certainly we would hope that most practices would spend at least some of this new money on such innovation, none of the report's three risk models actually require this. As was the case with the capitated Medicaid managed care organizations with which DSS contracted for years, which always professed "flexibility" to pay for services not covered under fee for service so as to better coordinate care, under such a risk model, flexibility can also mean flexibility to make more money by denying needed care, in this case in the form of needed office visits or other services, or through cherry picking patients.

> **Assumption 5:** This kind of financial risk should be experienced at the individual provider level.

As problematic as imposing financial risk on providers is, it is particularly troubling that the report, citing the CMS Healthcare Payment Learning & Action Network (LAN), encourages that these kinds of direct financial incentives "should reach providers across the care team that directly delivers care." (page 10). In other words, in addition to recommending that a primary care practice have a direct financial incentive to cut costs, it also recommends that individual providers be so incentivized.

This is a dangerous approach rejected even by a SIM Committee. The final report of the SIM Equity and Access Council recommended that any shared savings payments to ACOs include this protection against incentivized under-service:

> ***"Recommendation #3.7: Payment Distribution Methods.*** *To reduce the incentive for providers to under-serve in order to generate savings, provider groups at the sub-ACO level and individual providers should not be rewarded based on the portion of savings they individually generate. Rather, provider groups and individual providers should earn a share of savings that the ACO generates which is proportional to their own quality performance and the number of attributed lives on their panel."*
> http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-07-16/eac_phase_i_draft_report_062015.pdf (page 35)

As the Equity and Access Council's Report noted, "[b]y keeping the incentive to become more cost efficient at the level of the ACO or the provider group, rather than extending it to the individual provider, it is more likely that cost efficiencies will come from providers working together to manage utilization effectively, and not from inappropriate under-service." This protection was thus included in the design of the Medicaid shared savings model, PCMH+. This protection would be completely undermined if individual providers had a direct financial stake in saving money on their own patients' health care because of the fixed payments under bundles or capitation, as proposed in the SIM consultants' report.

> **Assumption 6:** There is no evidence of under-service or cherry-picking from imposing financial risk on providers.

The report fails to adequately address the **major** concern with shifting risk onto providers under all three of its options that under-service could result, declaring that "the literature review found no evidence to support that it occurs." Page 19. The statement is striking given the extensive evidence of under-service resulting from capitated managed care organizations in which, as with the proposed options, the entity is fully responsible for every dollar of health care (here, primary care) provided. While the risk models being advocated by SIM are new and untested, the basic financial incentive system is not, and time and again it has been shown to result in under-service. Indeed, this was a major reason why risk-based MCOs were pushed out of the CT Medicaid program. In addition, there is evidence in other states that provider risk models do result in adverse selection,[1] and SIM is proposing no protection in policy, monitoring or enforcement so that it will not happen in Connecticut.

Many, in addition to independent consumer advocates, have noted the risk of under-service and adverse selection from pushing risk onto providers. In the Project Management Office's Narrative for its application for grant funding for the SIM initiative, it noted:

> "CT acknowledges that *providers in [shared savings] arrangements may seek savings through under-service*, which might include reducing necessary access, inappropriate patient selection, cost shifting, withholding appropriate care or inappropriate referral practices. CT has established an **Equity and Access Council** comprised of physicians, consumer advocates, payers, and researchers from the state's public academic health center to develop methods that will help guard against such risks."
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> Connecticut SIM Model Test Proposal - Project Narrative, at page 11 (emphasis added).

SIM's Equity and Access Council met over many months and produced a 72 page report specifically to try to address at least some of those risks of under-service/adverse selection, including after a review of the literature at the time. The SIM consultants' report does not reference the Equity and Access Council's report, which is quite concerning considering the hundreds of hours spent by that Council's members, including consumer advocates, and the pertinence of this report to the analysis.

[1] J Hsu, et. al., Substantial Physician Turnover and Beneficiary "Churn" in a Large Medicare Pioneer ACO, Health Affairs 36: 640-648, April 2017.

Even SIM's own report in support of imposing risk on primary care providers notes, in discussing another less-aggressive risk model, "CPC+", that this model includes "some FFS reimbursement for certain services *to reduce the risk of under-service*." (pages 25-26)(emphasis added).

Finally, while the SIM Narrative sent to CMS recognized the risk of under-service/adverse selection from the imposition of shared savings, that risk is even **more** extreme under the proposed primary care payment models in this report, for at least three reasons: (1) shared savings involves "upside only" risk, not downside risk as under bundles and capitation, where significant amounts of money might be **lost**; studies have documented the more powerful incentive to avoid losing something one already has than to have the chance of gaining something additional, (2) putting financial risk on primary care providers directly means that patients might not be brought in for office visits when they should be, such that early diagnosis will be missed, which is less of a concern under a global shared savings model, and (3) as noted above, the options all assume that **individual** providers will be financially incentivized to save money on their own patients' health care, involving the kind of excessive and dangerous incentives which the SIM Equity and Access Council, and DSS, have warned about and guarded against. It is alarming that no acknowledgement, weight or deference was given to the these previous concerns, given that they were made specifically in consideration of Connecticut's program.

> **Assumption 7:** Whatever risk of under-service/cherry-picking there might be from imposing financial risk would apply only for the most extreme proposals for full capitation (Options 2 and 3), and is not an issue under "Option 1" partial bundled payments.

This assumption suggests that the report's authors do not appreciate the basic problem with imposing **any** kind of downside risk on providers. It certainly is true that imposing a partial or "'full bundle' of primary care services including 'sick' and preventive primary care services," i.e., capitation, as under Options #2 and 3, will "pose a risk of under service," in the form of discouraging visits, page 29. But that **also** is true for Option #1. Paying capitated payments for **65**% of the practice's annual income from "sick" visits, just as paying 100% of that income as under Option 2, absolutely incentivizes under-service because, under either of these models, there is either dramatically reduced payment (Option 1) or no payment (Option 2) for bringing a Medicaid enrollee identifying a medical issue into the office. On the margins, this powerful financial incentive will induce some providers, mostly unconsciously, to err on the side of **not** bringing the patient in. Yet, the only risk from imposing this kind of financial risk identified in the report for its Option 1 is "some risk that conversion to non-visit based care ***could jeopardize patient income***." (emphasis in original).

> **Assumption 8:** The shared savings model newly being imposed on Medicaid enrollees, PCMH+, is already a failure because it does not impose **enough** risk on providers, and we need to "move beyond" it to impose more risk on providers.

Ironically, the SIM Project Management Office, which forcefully pushed for imposing the shared savings/ACO model on Medicaid enrollees over the objections of agency staff and advocates, is now dismissing that model, which first went into operation in January of 2017, as a failure. Specifically, it declares that there are "limitations in the model that prevent providers from undertaking transformative change," so we must "move beyond shared savings program models." (Pages 1 and 6). But in so arguing, the proponents ignore that the first qualitative data on the implementation of the Medicaid shared savings program, and its effectiveness, will not be available until July or August of 2018. In addition, the problem with PCMH+ is **not** that it does not go far enough, but rather that it is **already**

imposing a risky experiment on vulnerable Medicaid enrollees with upside only risk. The answer is not to double down and INCREASE the risk on providers by imposing **downside** risk, which, as is well established in the literature, brings an even higher risk of harm through under-service.

> **Assumption 9:** Consumer advocates as a group **agree** with the SIM proponents that fee-for-service payment models are unsustainable, that we should transition away from it to risk-based payment models, and that any risk of harm to enrollees from imposing financial risk is worth it.

In service of defending its push for imposing full risk on primary care providers, the SIM consultants' report falsely paints a picture that there is consensus on the need to move beyond FFS and put financial risk on providers. *See* pages 3, 33, 36, 37, 38. In fact, this is extremely misleading. Even providers do not all agree. But particularly troubling is the report's attempt to suggest that **consumer advocates** agree with this position. E.g. "consumer advocates agree that the current FFS direction will not support the advancements in primary care needed to improve outcomes, reduce costs, and improve patient and care team satisfaction" and they "appreciate the significant benefits that PCPMs could have for consumers." (page 36, 38). In fact, consumer advocates, at least those representing Medicaid enrollees, overwhelmingly support maintaining the fee for service system tied to the use of compensated PCMHs, with rewards for improved quality, as has already been successfully demonstrated under the CT Medicaid PCMH (no "+") program. And the one consumer advocate on the SIM Practice Transformation Task Force who is a health policy expert, Shirley Girouard, Ph.D., voted **against** adopting any of the options in the report.

The report's authors attempt to conflate obtaining widespread consumer support with the fact that the SIM "Consumer Advisory Board" (CAB) at least vaguely supports its proposed models, declaring the CAB to "represent culturally and geographically diverse backgrounds" (page 36). While that may be true, it is hardly diverse on the question of whether imposing financial risk on providers is a good thing or a bad thing. The members of the CAB were appointed by the administration, directly or indirectly, and a primary concern was that such members be supportive of the SIM approach to payment reform, which is focused on imposing such financial risk. While certainly not all of the CAB members have committed to that position, most have. Thus, looking just to the CAB clearly does **not** accomplish the goal of getting broad "consumer representative" input.

Independent consumer advocates are overwhelmingly opposed to all three of the risk-based options in the report, and have expressed their concerns with the SIM push to impose financial risk on Medicaid providers in numerous letters addressed to SIM and officials overseeing it. A partial list includes: July 22, 2013 Letter to Health Care Cabinet, August 22, 2013 Letter to Lt. Governor Wyman, July 10, 2014 Letter to Lt. Governor Wyman and Dr. Mark Schaefer, September 12, 2014 Letter to CMS CMMI, April 10, 2015 Letter to Lt. Governor Wyman, September 28, 2015 Letter to Lt. Governor Wyman, March 8, 2016 Letter to Lt. Governor Wyman, Feb. 17, 2017 Letter to Lt. Governor Wyman.

IV. SIM Is the Wrong Place for Redesigning Medicaid

The report also wrongly assumes that SIM (and its committees), which is committed to the SIM PMO philosophy of imposing financial risk on providers through shared savings and similar "value-based payment reforms," is the right entity for deciding on payment reforms for the Medicaid program. The report declares that "There also needs to be a **pathway to the participation of Medicare and Medicaid**

to make any new approach to Connecticut a 'directionally aligned' multi-payer one" (Page 38) (emphasis in original).

It is not correct structurally for SIM to be redesigning any aspect of the Medicaid program administered by DSS, since federal Medicaid law establishes DSS as the single state Medicaid agency. SIM does not redesign or dictate to other payers, including those with populations less vulnerable to the risks of these payment models and those with more opportunity to generate savings. It is likely that, to date, SIM has only been rolled out in Medicaid because of its vulnerability as a government program, **not** because it is the right course to take for either Medicaid members or state taxpayers. It also would be very unwise policy: Unlike the MAPOC, the SIM steering committee is not comprised solely of individuals well acquainted with Medicaid policy.

The right entity for proposing or implementing Medicaid reforms is the Department of Social Services, with input and oversight from MAPOC, and its committees, which is populated by individuals with a strong knowledge base of, and commitment to, the Medicaid program and its participants. In fact, SIM's attempt to push the reforms in this report onto the Medicaid program has already raised concern with the co-chairs of the MAPOC. In a letter dated January 10, 2018 (attached), from the co-chairs to Dr. Mark Schaefer, they raised major concerns with the risk payment models in the report, if applied to Medicaid:

> "Since the Affordable Care Act was passed, hundreds of additional physicians now serve individuals in Connecticut's HUSKY Health Program. While we are always looking to make improvements to the healthcare system, new initiatives, like bundled payments for services, could have adverse effects. *This new payment methodology could lead to a reduction in providers willing to serve persons on Medicaid and create a gap in access to care and quality services.*
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> "Bundled payments are a new concept and relatively untested. It is not known how the new system would work in a State like Connecticut and how it would coincide with incentivized programs like PCMH and PCMH+. With all of the hard work Connecticut has put into building our Medicaid program, *we cannot risk the wellbeing of our citizens*." (emphasis added).

In any event, the MAPOC co-chairs concluded:

> "Finally, we would like to ensure that any SIM initiatives that could have an impact on Medicaid are brought before the Care Management Committee of MAPOC before being voted on. While we ourselves are members of the Steering Committee, a diversified group with expertise in Medical Assistance, like MAPOC and its Care Management subcommittee, can appropriately provide stakeholder input and oversight to anything that relates to Medicaid; as is statutorily directed."

V. Conclusion

The undersigned object to the recommendations of the February 1st SIM report and their proposed implementation. They disagree that the fee-for-service system is unsustainable and should be replaced by a system which puts financial risk onto providers, or that any of the three Options for putting downside risk on primary care providers set forth in the report are acceptable. Those three options impose an unacceptably high risk of harm, for little if any gain, particularly for vulnerable

Medicaid enrollees who already are having their care efficiently coordinated under CT Medicaid's successful non-risk PCMH program, but still face some access issues which would be magnified if their primary care providers were incentivized to deny them office visits. Lastly, we reject the misrepresentation in the report that consumer advocates broadly support the recommendations in this report and the assumptions made. Each of the three options should be rejected.

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