



## NEW ENGLAND REGION

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VIA EMAIL

November 25, 2013

Office of the Healthcare Advocate  
PO Box 1543  
Hartford, Connecticut 06144  
Attention: Victoria Veltri, Healthcare Advocate

RE: CT State Innovation Model

Thank you for the opportunity to provide comments on the State Innovation Model (SIM) plan. The Arthritis Foundation represents 23% of our state's adult population or 617,000 adults with doctor-diagnosed arthritis. More than 40% of these adults experience arthritis-attributable activity limitations. Two-thirds of those with arthritis are under the age of 65. We want to share our comments on the three parts of the model.

### **Primary Care Practice Transformation**

The model seems to be weighted toward larger group practices, which are better suited to the advanced medical home model. Yet, there are a large number of small group or solo practices in our state. They are going to be required to band together to gain the scale needed to achieve advanced medical home status. What evidence is there from other states or studies that this consolidation of resources will occur without affecting our supply of practitioners, particularly primary care practitioners?

The model proposes upside risk where providers share in gains but it also allows for downside risk where providers share in losses. We are concerned that this model may cause serious unintended consequences for patients by further restricting access to care, especially specialty care, such as rheumatology. The Equity and Access Council should develop a system that proactively monitors care delivery to insure that cost savings are driven "through quality improvement and more effective clinical decision making" not lower quality care or reductions in access to services. Providers with a pattern of reductions in access to services should not share in gains. The Equity and Access Council should also develop a system to allow both providers and patients a timely and transparent appeals process.

The report seems to contain conflicting information on the use of downside risk in Medicaid. In one place (Consumer Summary), it states that Medicaid providers will not participate in risk arrangements used in Medicaid, but in another (Provider Summary), it states that risk sharing will not be used in the early phases in Medicaid. We are concerned that the use of downside risk in Medicaid will further shrink the provider pool, especially for specialty care. Currently, Medicaid patients needing access to rheumatologist have to use two university hospital-based clinics. There are months-long waits for appointments, even if the patient has transportation. In rheumatology, delay in diagnosis and treatment contributes to joint destruction and attendant disability. We strongly recommend that downside risk is excluded from the Medicaid program.

The model seeks both to improve quality of care and save costs. It uses a population approach-seeking to address 80% of the state's population. Since just 5% of the population is responsible for half of all health care spending (Kaiser Family Foundation report), does the model address reducing costs in this group?

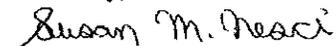
### **Community Health Improvement & Consumer Empowerment**

We applaud the model's public health approach to using evidence-based community services. It may be helpful to consider partnering with public health programs in our state's universities to develop an evidence base for newer approaches to either community health improvement or curricula for consumer education that may not yet have been studied or fully studied.

We are concerned that proposed consumer incentives, both positive and negative, to encourage participation in health and wellness be evidence-based and also monitored for unintended consequences of excluding certain populations. Rewards for nutritional purchasing only work if you have the money to purchase, access to high quality nutritional food, and training in adapting culturally sensitive cooking and seasoning methods. Many Medicaid recipients may live in food deserts with limited income, limited choices, and limited transportation to other options. Again with the Medicaid population, we strongly recommend that negative incentives be excluded.

Finally, we thank you for including two independent consumer advocates on the Steering Committee. A guiding principle in public health and community health improvement is to involve the people you are trying to reach and change in planning for that change. This includes both providers and consumers. Together, we can work to improve health, health care delivery and its costs in our state.

Sincerely,



Susan M. Nesci, MS, MA

Vice President

Public Policy & Advocacy

cc: Paula Haney, RPT, Chair, Public Policy Committee