NAMI Connecticut
National Alliance on Mental Illness

September 14, 2016

From: NAMI Connecticut
To: Members of the Health Care Cabinet
Re: Bailit Cost Containment Study and report

Dear Members of the Health Care Cabinet:

NAMI Connecticut is the state affiliate of NAMI, the nation's largest grassroots mental health organization dedicated to building better lives for all those affected by mental health conditions. NAMI Connecticut offers support groups, educational programs, and advocacy to improve the quality of life for individuals and families. Our work spans both public and the private insurance.
Like the Health Care Cabinet, various stakeholder groups and other community advocates, NAMI Connecticut is concerned about the rising cost of health care (attributable to a myriad of inter-related issues), particularly as it impacts individuals and families in their goals to achieve health and wellness, especially for persons who are dealing with several and complex health conditions. Thus, we understand the need to come up with and discuss proposals to try and address cost and related issues given the current Connecticut fiscal landscape. Nonetheless, We are writing to you today to discuss some of our key concerns regarding the cost containment study and report by Bailit Health Consulting, currently being considered by the Health Care Cabinet:

- *An almost exclusive focus on the public system/state employee system*. The legislation that authorized this study was intended to reach across all insurance settings – both public and private. And while we understand that there are different mechanisms and controls for each of these, it is imperative that the cost containment efforts do reach all the intended settings. And as has been noted in numerous statements and publications, Connecticut's Medicaid system has done well in regards to cost controls in the last several years. Thus, the intense focus on changes to Medicaid, at the expense or lesser focus on the other insurance settings, seems unresponsive to current issues and successes.
- As a state we can all be proud of the progress that has been made in Medicaid over the past several years, particularly through the *successful Medicaid Person-Centered Medical Homes (PCMH*), *which is a value-based innovation* and should be acknowledged and built upon. This program is improving access to care while controlling costs and does not practice shared savings or downside risk.
- Even though this report isn't directly about the State Innovation Model (SIM), it is clearly connected to this health reform effort. As such we as a state need to make sure *policy discussions had in regards to SIM and decisions and agreements made are reflected in this broader health care proposal.* Of particular concern is the seemingly aggressive push to move all Medicaid recipients into downside risk models. A commitment was made at the beginning stages of the SIM program, that no downside risk would be applied to or imposed on Medicaid populations throughout the five-year SIM grant. This commitment is crucially important to many

advocates and other stakeholder groups as this risk-based model can have very harmful unintended consequences to the care delivered to individuals. This is especially so for those with complex health conditions who require numerous interrelated interventions to achieve better health and quality of life. As these proposals, based on putting full financial risk on health care providers, have not been adequately tried and examined as to whether they are fulfilling their stated goals of promoting value-based care and improving health outcomes, it seems unadvisable and irresponsible to move vulnerable populations such as found in Medicaid into these models in the proposed timeframe, without a better understanding of all the implications of such risk-based models. For example, we need to be clear whether putting financial risk on providers actually promotes cost containment and increases access to and quality of health care.

- Understanding the appeal of a *'1115 Waiver' from the Centers of Medicare and Medicaid Services (CMS), we need to be clear about the potential drawbacks and harmful effects of such a proposal.* Namely, that while we may gain the flexibility of adding services not normally covered by Medicaid, the total cost of Medicaid services cannot be higher than at present; the changes must be budget neutral. This means that some of the current service expenditures would necessarily need to be reduced or cut.
- Understanding the appeal of creating a health reform office to oversee and direct the numerous pieces of health policy and implementation in the state, as there are so many entities working on different and sometimes overlapping health issues and populations, across insurance settings, we are concerned about the general inclusion of the Medicaid program. This, again, stems from the fact that individuals and families who rely on this public health care program have *distinct and most often more complex situations that impact their health,* often based on their low/very-low income and/or disability status which necessitates a more inclusive and comprehensive way of addressing the health of this population than is generally found in other insurance settings.
- One area that needs to be expanded on is social determinants of health. Everyone understands the critical importance of social determinants to population health, particularly for individuals and families who are living in challenging circumstances, including as they relate to housing, economic security, education and employment, transportation and other areas. However, addressing social determinants will likely require initial investments in time and other resources to realize any cost savings in the health care system, especially to its full extent.
- As a more viable alternative to quickly moving to downside risk payment structures and/or using a 1115 Medicaid waiver, we can grow and expand the successful value-based PCMH program. Beyond that, as has already been put in motion via the SIM process, we can and need to carefully review the first wave of using the upside risk-only approach through MQISSP/PCMH+ to see what the outcomes are and whether this should continue to be pursued. If not, other options should be explored.

Thank you for taking the time to review our comments and please feel free to contact me with any questions.

Genuinely, Daniela Giordano
Public Policy Director, NAMI Connecticut