Testimony of the National Alliance on Mental Illness (NAMI) Connecticut
Before the Health Care Cabinet
November 15, 2016

Comments regarding
Bailit Health Consulting Cost Containment Study and Cabinet's tentative report

Dear members of the Health Care Cabinet, my name is Daniela Giordano and I am the public policy director for NAMI Connecticut, 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 private insurance settings.
Like the Health Care Cabinet, numerous 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 here today to share some of our key concerns regarding the cost containment study and tentative report by the Cabinet, as well as support alternative proposals.

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 and quality of care while controlling costs and does not practice shared savings or downside risk.

One of the Cabinet's proposals (1A) recommends moving Medicaid recipients into downside risk models within a few short years. A commitment was made by the current administration at the beginning stages of the SIM program that no downside risk would be applied to or imposed on the Medicaid population. 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 beneficiaries 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.

Even though the expectation is that using downside risk models will create incentives for providers to improve quality, coordinate care, and reduce unnecessary services, the reality is that it more simply incentivizes the saving of money, however that is done. It could be done through improving care delivery, but it could also actually make the quality of care worse by incentivizing the denial of access to more

costly appropriate treatments, as happened under CT managed care not that long ago. For example, it could be that providers who significantly improve individuals' care would nevertheless have to pay money back if their care recipients happen to be more costly than expected.

A great part of the success of Medicaid in Connecticut has come from enlisting new providers, which had been a significant problem under the managed care model. Downside risk will be undesirable for a lot of providers who already feel that the Medicaid rates are too low and will drive them from participation in Medicaid. Also, understanding the intention of quality measures as a way to be sure that quality is improved and not diminished, we can all see that the status of current quality measures slated to be used with these models is completely inadequate simply due to the small number of quality measures compared with the number of health concerns with which individuals walk into providers' offices. It is a good beginning but it is not adequate for shared risk models.

We are very excited for the inclusion in this plan, and other efforts going on elsewhere in the state, of social determinants of health. We all understand 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, 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 that were not the case, then other options should be explored.

Understanding the appeal of creating an Office of Health Strategy that includes all insurance Settings to oversee and direct the alignment of health reform, particularly as it relates to cost containment strategies, we have strong concerns 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. A second reason is the fact that Medicaid's PCMH program, as noted earlier and noted in numerous publications, is a program that has been improving over the past several years, as it is engaging more providers, improving quality, improving access to care and patient satisfaction, and controlling costs – unlike the other settings in Connecticut's health care system. A third and very important reason is that this set up would effectively move control from DSS to this new office, infringing on DSS's responsibility of acting in the "best interests of the beneficiaries" as required by federal law, as well as the terms of the DSS-SIM Project Management Office formal protocol.

Rather than adopting the Cabinet's current plan to move to downside risk in Medicaid and create an Office of Health Strategy to facilitate implementation of downside risk, the Health Care Cabinet can instead recommend the alternative, with respect to its proposals related to the Medicaid, as was submitted to the Health Care Cabinet by twenty advocates on October 6, 2016.

As much as it is important to look outward to see what seems to be working for other states and regions, in a situation where CT represents a positive outlier of having done away with managed care in Medicaid, we need to pay attention to *what has worked for Connecticut* – including the following process and content areas:

- Inclusive, transparent process that engages everyone
- Access to timely data on how the program is working and using the data to address issues
- Commitment to delivery reform – with PCMH and intensive care management as a starter
- Commitment to continuing quality improvement
- Rebalancing long term services and supports
- Continuously innovating and addressing upcoming challenges

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

Genuinely, Daniela Giordano
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