Legal Services Advocates' Concerns with the Bailit Health Care Report Submitted to Health Care Cabinet with Respect to the CT Medicaid Program

- **A misplaced focus on Medicaid.** The legislation authorizing the Bailit report requires that all payers be examined in the report but the report focuses its attention mostly on Medicaid, an insurance program which already **has** great success in cost control.

- The July 12, 2016 Bailit report does not acknowledge the great success that Connecticut's Medicaid program is already having in controlling costs while improving access to care, or how the existing, successful Medicaid PCMH (not "PCMH+") program, which does not involve either shared savings or downside risk, is a successful **value-based** innovation which should be grown, not ignored.

- **Recommending an Aggressive Push to Force all Medicaid Enrollees into Downside Risk violates the commitment made to advocates and CMS.**

  Three years ago it was said to the advocates and CMS that CT would not impose any downside risk on any part of the Medicaid program throughout the duration of the five-year SIM grant. DSS and the SIM Project Management Office have repeatedly assured advocates orally and in writing that DSS would methodically roll out only upside risk through shared savings, and not use downside risk for any part of the population.

  - This commitment was made to address the threat of serious and irreversible harm that a risk-based model poses to enrollees, a model that has previously failed in CT Medicaid.

  - Violating that long-standing promise would largely destroy any credibility that the SIM initiative has with advocates, exacerbating the serious "trust among shareholders" problem correctly identified by Bailit.

  - **The report makes a false equation of putting financial risk on providers with inherently promoting "value-based care and improved health outcomes" and "paying for outcomes and improved health status."** In reality, the downside risk model being promoted simply puts pressure on risk-based entities to save money, not unlike the previous use of MCOs in CT Medicaid, and then simply **assumes** that saving money somehow equates with paying for quality, while it could actually worsen access to, and the quality of, care.

  - It would be irresponsible to aggressively move beyond upside risk in MQISSP/PCMH+ to the downside risk which Bailit is promoting, and which DSS has already wisely rejected for the Medicaid program, before we have even implemented the experimental MQISSP program, yet alone seen the results of the imposition of this experiment.

- **The proposal to obtain an "1115 Waiver" from CMS ignores the very high price of obtaining such a "flexibility" waiver.** While new services not normally covered by Medicaid may be reimbursed under such a waiver, the total outlays by the federal government under Medicaid must be neutral, such that some other traditional Medicaid expenditures must be reduced.

- **The purported benefits of alignment among payers promoted in the report has been wisely rejected in CT with respect to the Medicaid program, given the vulnerabilities of the Medicaid population particularly under a risk-based model, and the special obligations of DSS under federal law to look out for the "best interests" of Medicaid enrollees.** Bailit's proposal for an all-payer health care reform office with broad authority to tell other state agencies how to implement health care reform is highly problematic in the case of the Medicaid program since it would have control over DSS, violating the terms of both the DSS- PMO protocol and the best interests requirement.

- **The beginning of the Bailit model is devoted to "population health" but does not adequately address social determinants of health.** Effectively addressing social determinants is likely to an important way to control costs and promote quality in the long-term, particularly for the low-income population. But these issues are often ignored because addressing social determinants requires initial financial investments and will probably not result in quick health care costs savings, and the report does not explain how it would ensure this particular investment is made.

- **Rather than adopting the Bailit proposal to aggressively move to downside risk in Medicaid or adopt an 1115 waiver, we should grow the successful value-based PCMH program.** To the extent there is room to experiment in the Medicaid program with risk-based contracting under the upside risk-only MQISSP/PCMH+ program, we should do this very carefully with the roll-out of this program for the first wave, and then carefully study it before expanding to a second wave. Under no circumstances should we adopt the Bailit proposal to "move beyond MQISSP/PCMH+" to downside risk at any time before the SIM grant period has expired.

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