Proposed Alternative to Bailit Health Care Cost Containment Proposal Regarding Medicaid

The Health Care Cabinet has been considering a health care reform proposal put forward by the consultant Bailit Health Care. Recognizing the value of public and consumer input into major policy decisions, and that there is not yet an event scheduled to solicit this input, this document highlights issues raised by the proposal put forward for the Cabinet by Bailit in July, 2016. That proposal, largely reaffirmed by Bailit at the latest Cabinet meeting on September 13, 2016 and again in a webinar for the Medical Assistance Program Oversight Council on September 22, 2016, would directly threaten the major accomplishments made by DSS in developing innovations in Medicaid, which have been very successful in both improving care **and** controlling overall Medicaid costs. The undersigned write to urge an alternative to Bailit's proposal, as detailed below, following a brief discussion of the most serious problems with that proposal.

Some Major Problems with the Bailit Proposal as Concerns Medicaid

The Bailit report does not acknowledge the great success that Connecticut's Medicaid program, unlike all other health care programs in CT, is already having in improving access to care while controlling costs, with **negative growth of 1.9%** per member per month over the last four years. It also does not acknowledge that the existing, successful Medicaid PCMH (not "PCMH+") care coordination program, which already covers about 40% of Medicaid enrollees and does not involve either shared savings or downside risk, is a successful **value-based** alternative payment innovation which should be grown and applied to other payers, not ignored. Under this model, physical health care is already being coordinated with behavioral healthcare. The report seems to assume that unless a proposal is entirely new and involves downside risk, it can't work, and therefore gives essentially no credit to Connecticut's nationally-recognized success in cost control based on its successful non-risk PCMH value-based innovation. See *Wall Street Journal*, "Connecticut Moves Away from Private Insurers to Administer Medicaid Program" (March 18, 2016)(copy attached).

Recommending an aggressive push to force all Medicaid enrollees into downside risk threatens significant harm to Medicaid enrollees and violates the commitment repeatedly made to advocates, legislators and CMS, 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, on either a voluntary or mandatory basis. The latest presentation by Bailit, in a webinar for MAPOC members on September 22nd, acknowledges this long-standing promise to advocates for Medicaid enrollees, but then proceeds to recommend violating it by allowing provider groups to "voluntarily" participate (with incentives to make them want to do so), which effectively means that their Medicaid-enrollee patients will involuntarily be placed into downside risk.

- This commitment was made to address the threat of serious and irreversible harm that a downside risk-based model poses to enrollees because of the enhanced incentive for providers to reduce their own patients' total health care costs, a model that has previously failed spectacularly in Connecticut's Medicaid program.

- Violating that long-standing promise would largely destroy any credibility that the SIM initiative has with advocates and other stakeholders, exacerbating the serious "trust among stakeholders" problem correctly identified by Bailit as an obstacle to any health care reform and threatening the cooperation from independent advocates which DSS has been able to garner in developing the PCMH+ shared savings program.

- It would be irresponsible to aggressively move beyond upside risk in MQISSP/PCMH+ to the downside risk which Bailit is promoting, before we have even implemented the experimental MQISSP program, let alone seen the results of the imposition of this less extreme 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. Such a waiver is generally used by states to cut benefits. And the waivers have to be approved by the federal Medicaid agency, where leadership and priorities will be changing due to the upcoming election.

The purported benefits of alignment among payers has been wisely rejected in Connecticut 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 implement health care reform is highly problematic in the case of the Medicaid program since it effectively would have control over DSS, violating the terms of both the DSS- SIM Project Management Office formal protocol and the "best interests" requirement.

The proposal to impose a cap on the Medicaid program's cost growth is unnecessary and unenforceable except with the imposition of dangerous downside risk on providers. Connecticut Medicaid is already far ahead of all other health care programs in the state, with **negative** growth, so no cap is necessary. Under the Bailit proposal, such a cap also cannot be imposed except through imposing downside risk on providers, which, as noted, is dangerous and a non-starter for pursuing health care reform in the Medicaid program in Connecticut if the goal is to obtain buy-in from key stakeholders.

Proposed Alternative for Medicaid

- Rather than adopting the Bailit proposal to move to downside risk in Medicaid, to implement a dangerous 1115 waiver, to cap the budget of the Medicaid program, and to create an omnibus Office of Health Care Reform taking authority over the Medicaid program away from DSS, the Health Care Cabinet should recommend this alternative with respect its proposals related to the Medicaid program:

1. **Grow the successful value-based Medicaid PCMH program** by supporting DSS and enhancing its quality bonus payments for high performing PCMHs and PCMHs which have significantly improved under this alternative payment methodology, and include all kinds of primary care providers in this program, which has saved the state a lot of money already.

2. **Expand the successful Medicaid PCMH program to other payers** and offer technical assistance as DSS/CHNCT have done for Medicaid primary care providers

3. **Experiment very carefully with risk-based contracting under the upside risk-only MQISSP/PCMH+ program** (another program intended to coordinate care, including behavioral health with physical health care). Connecticut should do this very carefully with the roll-out of this program for the first wave in January of 2017, and DSS should then carefully study the impact for the first wave before expanding it to a second wave, to make sure it is not causing harm, is saving money and is worth continuing to pursue, consistent with its obligation to look out for the best interests of Medicaid enrollees.

4. **Not apply downside risk to any part of the Medicaid program,** on either a mandatory or "voluntary" basis, for providers or enrollees.

5. **Not test downside risk with any other Connecticut populations unless and until its safety and effectiveness is established in other states where it is being tried.**

Thank you for considering our carefully constructed alternative to what Bailit Health Care has proposed for Medicaid. Our proposal is designed to do no harm to Connecticut's substantial success in the Medicaid program, to ensure that this program's already-implemented value-based innovations are protected and grown, and to help restore the trust that independent advocates and other stakeholders need to have with health care reform planners and SIM proponents for any health care reform to proceed in Medicaid.

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