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**Testimony before Health Care Cabinet In Opposition to Preliminary
Votes on Certain Cost Containment Proposals Affecting Medicaid**

My name is Sheldon Toubman. I am a staff attorney at New Haven Legal Assistance Association with 26 years experience advocating for low-income Medicaid enrollees in Connecticut, mostly with access to care problems. I am also one of the advocates who ran the campaign over a decade to rid our Medicaid program of the risk-based MCOs which systematically denied access to needed care, while refusing to be held accountable and driving up our Medicaid budget. I am here today to speak in opposition to the proposal to move to downside risk in the Medicaid program starting in January, 2019, and to create an Office of Health Strategy which would have jurisdiction over Medicaid in order to facilitate the move to downside risk. Both of these proposals are harmful to Medicaid enrollees and the Medicaid program in general, threatening the nationally-recognized success of our program since we moved beyond MCOs, and should be rejected.

The recommendation to set up Consumer Care Organizations (CCOs) to move all Medicaid enrollees into downside risk in the near future (Proposal 1A) should be rejected. That proposal:

- threatens significant harm to Medicaid enrollees
- is not supported by the theory upon which it is based
- conflicts with the reasons the commitment was made to advocates and legislators
- exacerbates trust problems, and
- directly conflicts with the proposal to build on what is working in CT Medicaid** by
 - (1) destroying the PCMH program which has improved care and saved a lot of taxpayer money, and
 - (2) encouraging providers to depart from the program.

Presentations to the Cabinet have assumed that putting financial downside risk on providers to incentivize them to save money would result in it being saved only the right way, ignoring the harm downside risk could do to vulnerable Medicaid enrollees whose providers will be put in a conflict of interest situation with their own patients. This has been justified based on the current trend toward imposing such risk, which may not last.

Proponents have argued that applying downside risk to providers will provide incentives to coordinate care and reduce unnecessary services. Specifically, Bailit's summary of the 1A proposal preliminarily adopted by the Cabinet says that the adoption of CCOs with downside risk will "engage providers to provide services in a more coordinated effective and efficient manner." (page 3). But the reality is that the downside risk model is entirely agnostic about such things - it

just incentivizes **the saving of money, however done**, not necessarily through improving care delivery; it could actually make the quality of care **worse** by incentivizing the denial of access to expensive appropriate treatments, as happened under Medicaid managed care in the 1990s and 2000s. The statement that downside risk incentivizes better care coordination and thus improvements in care is actually just a hope. And the supposed check of quality measures will be wholly insufficient to prevent harm from denied care, given the very limited number of such measures. The focus of downside risk on saving money however done is clearly illustrated by the fact that, under this model, providers who **significantly** improve care under downside risk will nevertheless have to pay money back to the state if their patients happen to be more costly than expected.

The commitment to advocates and legislators to avoid downside risk in Medicaid was made **not** to give time to set up downside risk as the next step after shared savings but rather to address the concerns of harm to Medicaid enrollees and to the successful Medicaid program resulting from its imposition. Rejecting that long-standing promise would largely destroy any credibility with advocates and other stakeholders, exacerbating the serious “trust among stakeholders” problem correctly identified as an obstacle to any health care reform.

It also would be irresponsible to commit **now** to moving in the future beyond upside risk in PCMH+ to the downside risk model, before we have even implemented the experimental PCMH+ program, let alone seen the results of the imposition of this less extreme experiment. Recent changes in policy and changes to weaken consumer information about the new program could have already jeopardized the future of PCMH+. It is unwise to plan for downside risk now, when we don't know if even upside-only risk, which is itself controversial because of the lesser incentives to deny appropriate care, will work and avoid harm to current Medicaid success.

Although it was asserted at the November 1st Cabinet meeting that voting for the proposal to move to downside risk in Medicaid (proposal 1A) was fully consistent with proposal to “build on” what is working well in Medicaid (proposal IB), moving to downside risk in Medicaid in fact **directly conflicts** with the current successful Medicaid model. Almost all of the discussion of what is working in Medicaid talks about the PCMH+ program, which is not yet in effect, and largely ignores the great success already of the non-risk, non-shared savings PCMH (no “+”) program now covering 43% of Medicaid enrollees, which has been in effect for four years.

Moving to downside would be **destructive, not supportive**, of the current success under PCMH (not “+”) in the Medicaid program in two critical ways:

First, under PCMH, primary care providers act as “honest brokers” in deciding what treatment or services are needed from other providers- they get paid neither more nor less from making such referrals or prescriptions, but under downside risk money will directly come out of their pockets if they prescribe treatments which exceed what a formula projects it should have cost, so they will necessarily have a strong incentive to avoid recommending costly treatments.

Second, one of the great successes of Medicaid has come from enlisting new providers, which had been a significant problem under the MCO model; downside risk is undesirable for a lot of providers who already feel that the Medicaid rates are too low and will drive them from participation in Medicaid. By destroying PCMH and driving out providers who can coordinate care and assure access to timely care, the engine of savings in the Medicaid program, downside

risk could directly undermine what is working today in Medicaid, including the saving of a lot of money under the program. In sum, moving to downside risk will destroy the Golden Goose.

Finally, there has been a lot of misinformation suggesting that proposal IA does not require downside risk in Medicaid but just keeps it open as an option. But that is not what the proposal the Cabinet voted for says. According to Bailit's summary of what has already been voted on, at page 7, DSS starts contracting with CCOs on January 1, 2019, most CCOs move into shared risk/downside risk by January 1, 2020, and all CCOs are **required** to be in downside risk by January 1, 2021. The only escape from this schedule would be if the Office of Health Strategy chose to alter it, which is itself problematic, as discussed below.

Accordingly, if recommendation 1A voted upon becomes law, downside risk effectively becomes mandatory for all or almost all Medicaid enrollees - including extremely vulnerable individuals with severe disabilities - in slightly more than four years from now. This will harken a return to the kind of risk Connecticut's Medicaid program spent several painful years extracting itself from, though at least then the risk only applied to the relatively healthy family population, and with the supposed protections against what happened with the MCOs as ineffective as they were then.

The proposal for an all-payer Health Strategy Office with broad authority to implement “aligned” health care reform is highly problematic.

Medicaid is unique for a host of reasons – including that it covers a very different population from the population at large, with greater health needs and fewer resources for both patients and providers. It also is an improving program that is engaging more providers, improving access to care and patient satisfaction, and, most importantly to your charge, controlling costs – unlike the rest of Connecticut's health care system.

The purported benefits of alignment among payers have 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 unique success of that program. The Cabinet's proposal for an all-payer Health Strategy office is highly problematic in the case of the Medicaid program, since it would inappropriately force such alignment and effectively take control of the program from DSS, violating the terms of both the DSS-SIM Project Management Office formal Protocol and the “best interests of the beneficiaries” requirement in federal Medicaid law.

Proposed Alternative for Medicaid

Rather than adopting the Cabinet's current plan to move to downside risk in Medicaid, and to create an omnibus Office of Health Strategy taking authority over the Medicaid program away from DSS so as to facilitate implementation of downside risk, the Health Care Cabinet should instead recommend this alternative with respect its proposals related to the Medicaid program, as submitted to the Health Care Cabinet by 20 advocates on 10/6/16:

A. Grow the successful value-based Medicaid PCMH (no “+”) program

--enhance its quality bonus payments for high performing PCMHs and PCMHs which have significantly improved

--include additional kinds of primary care providers in this program

B. Expand the successful Medicaid PCMH program to other payers. Offer technical assistance as DSS/CHNCT has done for Medicaid primary care providers. Shift from one-size-fits-all financial risk models to more sophisticated, data-driven models that are both improving quality and access, and controlling costs.

C. If CT is to experiment with risk-based contracting under the upside risk-only PCMH+ program, do this very carefully. Carefully study the impact and the results (does it actually save money? harm access?) for the first wave in January of 2017, before expanding it to more Medicaid enrollees.

D. Not plan to apply downside risk to any part of the Medicaid program, on either a mandatory or “voluntary” basis, for providers or enrollees.

E. Not test downside risk with any other Connecticut populations unless and until its safety and effectiveness is established in other states.

Thank you for considering this testimony.