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September 12, 2016

Legal Services Advocates' Comments to
Bailit Health Care Report Presented to Health Care Cabinet

Introduction

The below-named advocates, who represent low income Medicaid enrollees with access to care issues on a daily basis, write in response to the Bailit report produced for the Health Care Cabinet and presented at its meeting on July 12, 2016 ("Study of Cost Containment Models and Recommendations for Connecticut"). While the authorizing legislation requires the report to address all payers, the authors of this report focus on Medicaid and state employees' healthcare. The report makes three key recommendations of grave concern to us, as advocates for Medicaid enrollees:

First, the proposal recommends aggressively moving all Medicaid enrollees into downside risk arrangements. This recommendation does not account for the great success that Connecticut's Medicaid program is already having in controlling costs while improving access to care. Moreover, such a move would be in direct conflict with the repeated promises made by various state agencies to advocates, as well as CMS, that under no circumstances would downside risk be applied to anyone on Medicaid throughout the duration of the SIM grant period.

Second, the report proposes that Connecticut obtain an "1115 Waiver" from CMS. Such a waiver would enable Connecticut's Medicaid program to pay for new initiatives but the report fails to account for the need to reduce costs for existing expenditures that would be necessary for such a proposal to be approved.

Third, the report proposes putting Connecticut's Medicaid program within a newly-created Office of Health Care Reform without regard for the requirement of federal law that makes Connecticut's Department of Social Services the single state agency charged with administration of that program.

Each of these concerns is discussed below.

Moving Medicaid Enrollees Into Downside Risk Arrangements

The charge to the Health Care Cabinet, as well as Bailit, was to study cost containment strategies for **all** payers. Connecticut's Medicaid program has achieved substantial successes-including a net 5.9% **deflation** in per member per month costs in the previous fiscal year, and a 1.9% deflation rate over the period from SFY 2012 through SFY 2016 -- quite a rare feat in our nation. Connecticut's remarkable success in cost control and quality has gained national

recognition, such as in a March 2016 *Wall Street Journal* article detailing how we moved from risk-based contracting to use of non-risk ASOs and patient centered-medical homes, and reduced ER usage in the process. The Bailit report does not account for this in its analysis, instead emphasizing Connecticut's health care per capita spending **in general**, not separating out the low costs of Medicaid, see slide 19. Similarly, when talking about quality in Connecticut health care **generally**, slide 20, the report does not account for the significant gains in ER usage reduction in the Medicaid program.

In particular, Bailit's September 1st supplemental memorandum, entitled "Why Shared Risk Models Should be Considered by the Cabinet," which provides Bailit's reasoning for this recommendation, Bailit overlooks the significant success of Connecticut Medicaid's PCMH program, a value-based program. This program covers roughly 40 percent of all Connecticut Medicaid enrollees. Under this growing program, Medicaid primary care providers who gain national accreditation as patient-centered medical homes are paid extra for coordinating all care of their patients and in addition get paid bonuses for doing well on carefully developed quality measures. Under this value-based payment methodology, the providers do not get paid extra for saving money directly but they are rewarded for doing well on various quality measures, such as emergency room usage reduction and hospital readmission reduction, which inevitably do save money. Providers do not have a stake in deciding whether to send someone out for a referral to a specialist or not, aside from the well being of their patient, a central element of this successful, innovative program which has successfully improved health outcomes while saving the state tens of millions of dollars.

While overlooking Connecticut's successful non-risk PCMH model as an optimal choice, the Bailit report instead cites examples of risk-based "ACO programs in Medicaid" in three states which are saving less money than Connecticut is saving under our PCMH model (slide 37). It would be a grave mistake to not acknowledge or, worse, disregard, the value-based PCMHs and intensive care management CT has had remarkable success with in Medicaid. It is working well for both Medicaid enrollees and providers, as well as for state's taxpayers. Indeed, it is not clear that moving to risk-based models would in fact save money. In Medicare, where ACOs have been most heavily promoted and applied, many of the entities have been found to have actually **increased** costs overall for the Medicare program.

Bailit's analysis oversimplifies the financial risk it proposes to place on providers, ultimately full financial risk, equating it with promoting "value-based care and improved health outcomes" and "paying for outcomes and improved health status" (slides 25, 28, 33). Indeed, in its most recent presentation for the September 13, 2016 meeting of the Cabinet, Bailit categorizes as an unquestioned "Benefit" that its financial risk proposal "pushes risk down to the providers" (Slide 10), without any explanation of how this actually benefits Medicaid enrollees or improves their care.

As explained in its September 1st paper encouraging down-side risk for Medicaid:

> **According to economic theory, individuals have a greater response to a risk of loss, than they do to the possibility of reward.** Applying that to health care, it's reasonable

to expect that providers will be more responsive to ***improving care delivery*** if they are in a shared risk arrangement, rather than in a shared savings arrangement.

Page 4 (emphasis in original, and then added).

The model Bailit is promoting simply puts pressure on risk-based entities, not unlike MCOs which CT rejected for its Medicaid program, to save money, through the use of downside risk (slides 45 and 48) and ultimately full risk (slides 28, 34, 36), and then **assumes** that saving money equals paying for quality, when it could instead significantly **reduce** access to care or the quality of care. Bailit's stated assumption above about downside risk based on "economic theory" might be correct **if** the phrase "improving care delivery" was replaced with "saving money," since that is really the only thing directly incentivized under a downside risk model.

Risk-based systems do no necessarily encourage efficiency, care coordination or quality of care at all; they may force lower expenditures simply because, under such a model, the cost of providing care comes directly out of the risk-based entity's bottom line. This was Connecticut's experience with MCOs until they were finally terminated from the Medicaid program four years ago. Such systems could result in lower costs simply by stinting on needed care, with no increase in "value," or even **lowered** health status, but still be deemed a success based on the narrow test that they saved money for the payer, which in this case would be the Medicaid program.

Bailit's focus on moving to risk-based contracting in Medicaid introduces its proposed new "Consumer Care Organizations," as "designed to accept shared risk with the state and ***move beyond MQISSP*** –MQISSP is an important step to prepare organizations to become CCOs." (emphasis added). But MQISSP (or PCMH+) is not yet tested and is a controversial program. While it involves only upside risk, the risk of incentivizing under-service is still present. This limited risk model has not yet been implemented in Connecticut and it would be irresponsible to aggressively move **beyond** upside risk in MQISSP/PCMH+ to the downside risk and full risk which Bailit proposes before we have even implemented MQISSP, yet alone seen the results of this experiment.

Moreover, Bailit's proposal to aggressively move to downside risk conflicts with the commitment made both to CMS and to the advocacy community three years ago that, while Medicaid would be moving to upside risk, it would **not impose any downside risk on any part of the Medicaid program throughout the duration of the five-year SIM grant**, largely because of the above concerns. This is made clear in the formal plan document submitted to, and then approved by CMS, in December of 2013:

> The Department will, based on the early experience of other payers with this approach, assess the need for protections for Medicaid beneficiaries and on this basis will determine when during the test grant period to implement an upside only shared savings program. (Page 98).

In the PMO's Test Grant Narrative submitted to CMS in July of 2014, it reiterated that commitment: "DSS will use its current PCMH retrospective attribution methodology to evaluate performance and determine eligibility for **upside-only** SSP payments." Page 10 (emphasis added).

It would destroy any credibility that the SIM initiative has with advocates to go back on this express promise. In addition, it would be following an earlier breached agreement by SIM, in which SIM agreed that shared savings would be tried first and analyzed in other populations before being applied to Medicaid enrollees. Both DSS and the PMO have attempted to bridge the resulting gulf with independent advocates by repeatedly assuring the advocates (as well as CMS) over the last three years, orally and in writing, that **only** upside risk would be applied to Medicaid, as memorialized in the final, approved plan submitted to CMS.

Bailit correctly notes in its report that a major problem with moving forward with any kind of reform in health care is a problem of trust. It identifies as the number one Challenge Connecticut Needs to Address "Lack of trust among key stakeholders." (Slide 22). Clearly, proposing to vitiate the commitment of no downside risk until at least the completion of the SIM grant period, during which only upside risk will be imposed on Medicaid enrollees, would exacerbate that acknowledged severe problem already confronting our state.

Proposal to Obtain an 1115 Waiver

Also troubling in the report is the proposal to obtain an "1115 Waiver" from CMS. While the virtues of "flexibility" under such a waiver is emphasized in the report, see slides 53-58, the report fails to note 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. Put simply, this means that some other traditional Medicaid expenditures must be reduced in order to spend money on the new initiatives. In other states, such waivers have generally been used as a vehicle to cut essential protections, and they must be viewed with extreme caution.

Proposal to Create an Office of Health Care Reform

Throughout the report, Bailit emphasizes the purported benefits of alignment among all payers, see slide 71. But this approach has been wisely rejected in Connecticut with respect to the Medicaid program, given the special vulnerabilities of the Medicaid population, particularly under a risk-based model, and the special obligations of DSS under federal Medicaid law to look out for the "best interests" of Medicaid enrollees.

Related to this, Bailit proposes an all-payer health care reform office with broad authority, substantially beyond the SIM Project Management Office, to tell other state agencies how to implement health care reform. (slides 25, 43-48, 72-76). This proposal is extremely problematic in the case of the Medicaid program. DSS is required by federal law to look out singularly for what is in the best interests of Medicaid beneficiaries, not other consumers, and not providers or other payers. Indeed, a formal protocol between DSS and the PMO had to be developed to ensure that DSS had the final say in **all** decisions about the Medicaid program. But, under the Bailit proposal, the health reform office would have control over DSS, violating the terms of both the protocol and federal law, and removing a critical protection for this vulnerable group. That would be troubling in any event, but particularly so given Bailit's central focus on returning the entire CT Medicaid to downside risk-based contracting with its inherent

incentives to under-service in order to save money, in violation of the commitments made to the advocates and CMS three years ago.

Conclusion

The Health Care Cabinet should not adopt the Bailit report's proposals of rapidly returning the Connecticut Medicaid program to risk-based contracting, implementing an 1115 waiver, and taking authority away from DSS to make all decisions on health care reform affecting Medicaid enrollees. Rather, it should recognize the significant cost decreases experienced since DSS moved away from such contracting and embraced non-risk ASOs and value-based PCMHs instead. We should develop a plan to expand and **grow** the current non-risk PCMH program. To the extent there is room to experiment in the Medicaid program with risk-based contracting under the upside risk-only MQISSP or PCMH+ program, we should do this very carefully with the roll-out of this program for the first wave in 2017, and then carefully study it before expanding this program to a second wave.

Under no circumstances should we adopt the Bailit proposal to "move beyond MQISSP" to downside risk and full risk, before that experimental program has been rolled out and analyzed for potential harm to vulnerable Medicaid enrollees, and under no circumstances should the Medicaid program incorporate during the SIM grant period any downside risk, which is the central proposal of Bailit for that program.

Thank you for considering our comments.

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