Behavioral Health Partnership Oversight Council

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Via email

December 1, 2016

Lieutenant Governor Nancy Wyman
State Office of Connecticut Office of the Lieutenant Governor
210 Capitol Ave. – Room 304
Hartford, CT 06106

Re: Healthcare Cabinet Cost Containment Recommendations

Dear Lt. Governor and Members of the Health Care Cabinet:

We recognize that you have heard testimony and commentary from a wide variety of organizations and advocates **regarding the proposal to put Medicaid enrollees into a Downside Risk Payment Model.** We wish to add our perspective as representatives of the oversight body concerned with the provision of behavioral health services to the hundreds of thousands of children and adults on HUSKY.

While there are many laudable ideas in this proposal, we share deep concerns that this model would pose several major risks to individuals in need of mental health and/or substance abuse services. As you know our state created the Behavioral Health Partnership in 2006 – originally for children and families - and later for all enrollees in Medicaid, because individuals (in particular children) were not getting the mental health services they needed under capitated managed care and which shifted costs to the Department of Children and Families for institutional care.

Those with serious or severe mental health and/or substance use disorders remain particularly vulnerable to being marginalized notwithstanding the gains our state and nation have made in fighting the stigma historically attached to such conditions and providing life-saving and life-affirming treatment options.

Some of our concerns, very briefly, are as follows:

The proposal includes a provision that would require providers to return money to the state if the total cost for care (TCOC) for their clients exceed a certain cap. Despite the notes that the model would use a TCOC target that "…will be risk-adjusted and high cost outlier cases will be

truncated at a predetermined threshold..." (P.5 in the proposal) this kind of strategy has often proved inadequate for providers that serve a large number of such individuals. **This type of approach may provide a disincentive for health care providers to serve the most seriously ill individuals.** The model also provides for "shared savings," again a potential disincentive to serve complex, high need individuals and groups.

The shared risk component could result in providers who serve the most high-need and high-risk individuals to no longer accept Medicaid if they have to return money after the services have been provided. This is already a problem given that participation in Medicaid is voluntary, and given the low participation rate for some specialty health care providers. Such **a reduction in "willing providers" could reduce access and thus negatively impact health outcomes**.

Our Council is in the process of focusing more intentionally on health care disparities in the HUSKY program. We are doing so because this population is by definition poor. Many HUSKY members suffer from mental illness or substance use disorders, and/or come from minority populations, as noted by many other commenters to the proposal. This proposal could worsen the already discrepant outcomes and early mortality for those on Medicaid, despite a stated goal of improving their overall health.

Needless to say we are also concerned about the impact of the proposal at a time when there is so much uncertainty about the future of Medicaid on the federal level. We therefore urge you to vote "no" on this proposal until these and other raised concerns can be addressed.

Respectfully submitted,

The Executive Committee of the
Behavioral Health Partnership Oversight Council:

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Terri DiPietro

Steven Girelli

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