Health Care Cabinet Proposal for CT Health Reform:

What it is, Response, Alternatives

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“Burning platform”

- This year premiums up 25% individual and 13% small groups, on and off exchange
- Horizontal consolidation – hospitals and insurers, will raise prices even higher
- Vertical consolidation – ACOs, big health systems, raises prices as well, no evidence for improved quality, care coordination mixed
- CT quality of care – average to poor
  - Esp for hospitals and community health centers

– Still 211,000 uninsured

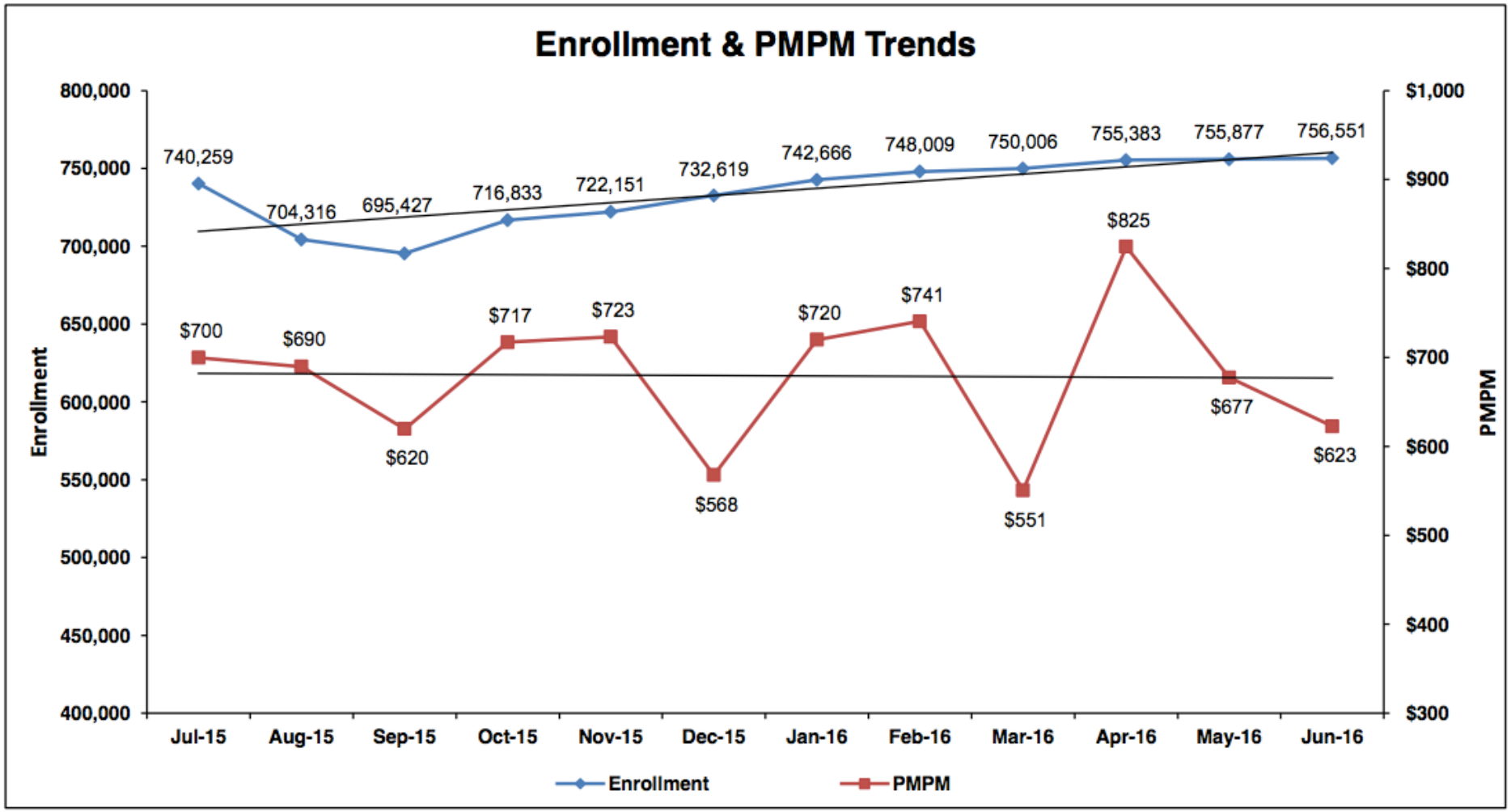
– Market push toward “alternative payment models”, “value-based payments”

Medicaid improvements since 2012

Medicaid not part of burning platform

- 92% of adults and 96% of children can get immediate care when needed
- 93% of adults and 98% of children report positive experiences with the program
- ED visit, hospital admission rates down
- Secret shopper survey – now can get appt with 64% of providers
  - Only 14% told availability based on Medicaid
  - Only 7% felt unwelcome/discouraged from making appt

Costs stable, enrollment up



Medicaid is unique

First, do no harm

- If Medicaid can do it, anyone can
- Rest of CT's burning platform should be learning from, copying Medicaid
- But general problems outside Medicaid drive solutions to those problems
- Then policymakers apply the solutions only to Medicaid, because they can't touch other programs
- And we are on defense to control the damage

Bailit's Strawman proposal

- SB-811 passed in 2015 directed Cabinet to develop reform, cost-control, value recommendations to Gen Assembly by Dec. 1, 2016
- Being led by Vicki Veltri, chose Bailit
- Funded by CT Health Foundation, also Universal Health Care Fndn of CT, Fndn for Community Health, and Donaghue

Bailit's Strawman proposal

- Studied other successful state reforms
- Got input from state agencies on reform efforts
- Key stakeholder interviews, but didn't listen
- Bailit published a Strawman proposal
- Voted by Cabinet last week, provisional vote
- Can change vote based on public input Nov. 15
- Will take up drug cost control measures after this

Bailit's take on CT

- Trust issues – got this right
- "Burning platform" of health care costs
- Quality mediocre
- Disunity between state agencies
- "Steady habits" = backward state needs to come into the new reality of health reform
- For-profit, multi-state insurers – also right

Concerns with proposal

- All about SIM
  - Adopt CCIP for all
  - Adopt SIM quality measures
  - Adopt SIM APM goal
- Empire-building
- All about putting risk on providers
- Misses what is really needed
- Little on social determinants, public health
- Very very weak on quality improvement
- Wrong goals and doesn’t even address them

Concerns with proposal

- Would make distrust worse
- All about trickle-down decision making from “experts” at the top
- All about payment, very weak on delivery reform, real population health measures
- Missed CT’s unique positives and negatives, promises, experiences completely
- All about state control, state budget deficits
- All about following the feds

Bailit's proposal

- **Goal 1** -- Implement delivery system reforms designed to promote value-based care and improved population health outcomes.
- Their solution –Shared risk ACOs for "aligned" purchasing of HUSKY and State Employee plan to promote efficient use of services and improve quality.
- Passed -- 13 to 4 (OPM, DSS, DPH & CTHPP)

Shared/downside risk

- Provider networks (ACOs) paid on FFS basis all year
- At end of year, decide if they spent more or less than expected (TCOC)
- If less, they get part of the savings
- If more, they have to pay back part of the extra
- Breaks repeated promises not to implement downside risk for Medicaid
- May be able to do this for state employees without opening collective bargaining

Problems with shared risk

- Same incentives to deny care as capitation which "failed spectacularly"
- Very experimental, even in "advanced states"
- Medicaid "underpays" providers, how will they save?
- Incentives to deny necessary care, no monitoring for underservice
- Loss aversion -- worse/better to force cost control as providers would have to pay money back

Problems with shared risk

- Reduces incentive to invest in care coordination, analytics, social services, etc.
- Increases uncertainty as providers will find out if they get a bonus or penalty many months after treatment and investment decisions are made
- Disrupts patient-provider relationship, destroys trust
- Providers will leave Medicaid
- CT Medicaid already saving more than their example states
- “aligning” state employees and Medicaid – a vast disaster we’ve tried before

Why they say it won't be like last time and why they're wrong

- We have data/analytics now to know what's working
  - Data and analytics are still elemental, no clinical data
  - We had enough to know there were problems last time, the problem was no political will to do anything about it
  - Strong indications that it will be exactly the same this time
- Risk adjustment – no reason to avoid sicker members
  - Risk adjustment is very new and "game-able"
  - Literature about inaccuracies
  - Little trust of methodology
- Quality benchmarks
  - Aligned and homogenized so they are meaningless
  - Very narrow, short lists
  - Easy A's
  - Only pregnant 3-year olds with diabetes are covered

Solution C

- Community Health Teams
- Similar to VT Blueprint for Health
- Multipayer supported
- Provides care coordination, health/wellness coaching, BH counseling, outreach, other services
- Available to all practices by geography
- Saves money, very popular in VT
- Reduces waste
- More options for access to care
- Better data to track chronic illnesses, evaluate social interventions, link to communities and public health
- Passed -- 14 to 3

More goals

Goal 2 -- Control costs and offset the price effects of provider market consolidation

Solution -- limit per capita health cost increases, includes Medicaid, make enforceable APM targets, create an Office of Health Strategy, a new agency to measure everything and decide on how to control costs, did remove penalties, just reporting and Plan of Correction

Problems -- $$$, new agency with vast control, reduces trust, APMs are a backdoor to downside risk, “like capitation for the whole state”

Action – revising cost growth cap, APM targets failed 8 to 9

More goals

Goal 3 – Coordinate and Align State Strategies

Solution – was to merge all state agencies that touch health, then create a Health Policy Council and Office of Health Strategy

Problems –Policy Council – too many meetings, duplicates other committees, want consolidation of state policy groups

Cabinet position – they want to be the deciding group

Office of Health Strategy -- $$, trust, no data to work with

Outcome – no Council, but Office passed 13 to 3

Yet more goals

Goal 4 – Support market competition

Solution – Give AG subpoena power

Problems – then what?, already getting info
Jan. 1, there is a CON taskforce

Passed without a vote

And more goals

Goal 5 – Support providers to transform (to downside risk)

Solution – 1115 waiver and DSRIP

Problems – has to be budget neutral for fed.s, state has to come up with matching $$$, all to support downside risk

Upside – they agreed to put “guard rails” around possible bad things (reductions in services or eligibility), changed to “study and seriously consider”, passed 14 to 3

Yet more goals

Goals 6, 7 – Use data to make policy

Solution – APCD, HIE, CER, evidence-based coverage

Problems – tried it, no $$$ and others are ahead of us, we can use their tools now, patient groups will not like it, all controlled by a brand new committee

Passed – CER narrowly passed when LG broke the tie

CTHPP alternative

- **First, do no harm** – no downside risk encouragement
  - Especially not for Medicaid
  - We can't stop the feds (if that even happens) but we don't need to fall down the same rabbit hole
- **Build on what's working in CT**
  - Medicaid
  - Care coordination
  - Quality incentives and disincentives – esp those that save $$
- **In defense of non-alignment** – not one-size-fits-all
- **Underservice monitoring** – real, not short quality lists
- **Protect consumer choice**

To build trust

- **Biggest barrier to progress --** will be very hard
- Not about “tables” or top-down “experts” or empire-building/ consolidation
- Number 1 – **state must honor commitments** – and not just until they are inconvenient
- Start small with easy wins to build trust – and because that’s all we can afford right now
- Emphasize communications – two way, within state and with the rest of the health care system
- Strong conflict of interest prohibitions – plenty of ways to get input without giving away the store
- Meaningful consumer engagement

CTHPP alternative

- Invest in delivery reform, public health, social services
- Expand successful care coordination, intensive care management,
- Focus on high-need, high-cost members with proven supports
  - This is where both the $$ and the need are
- Regulate ACOs and large health systems
  - Stress tests for too-big-to-fail health systems
- Limit provider mergers, monopolies
- Hold off on 1115 waiver – political landscape here and in DC is in flux

CTHPP alternative

- Pilot everything, see what works, adjust as necessary, see if it can be scaled up or not
- Real efforts to lower premiums
- Control drug costs
  - Safeguard high quality care, consumer access to necessary medications, flexibility depending on circumstances
- Use data in decision-making but wisely, not blindly, use what is already working
  - Use other options i.e. ICER, HUGO
- Quality improvement – for its own sake

Independent Advocates' Alternative

Submitted by 20 advocates to Health Care Cabinet on 10/6/16

Sheldon Toubman

New Haven Legal Assistance Assoc.

Concerns about Downside Risk

- Lack of acknowledgement of Medicaid success under value-based PCMH (not +) model which coordinates care and rewards performance
- Equation of health reform with downside risk on provider
- Promise not to do downside risk **not** made to buy time to set it up, but out of concern for serious harm that could result
- Violating the promise would exacerbate the serious trust problem identified by Bailit
- Irresponsible to commit to downside risk plan when we have not yet rolled out upside risk PCMH+, let alone analyzed results of this less extreme experiment

Other Concerns

- Section 1115/DSRIP waiver could harm access because of cost neutrality requirement
- Alignment and new office of health care reform governing all payers bad idea because of interference with Medicaid enrollees' "best interests"
- Capping Medicaid growth unnecessary given success in Medicaid cost control, and would be done as part of downside risk"

Independent Advocates' Alternative

1. Grow the successful value-based Medicaid PCMH program

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

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

Independent Advocates' Alternative

2. Expand the successful Medicaid PCMH program to <u>other</u> payers. Offer technical assistance as DSS/CHNCT has done for Medicaid primary care providers.

Independent Advocates' Alternative

3. If CT is to experiment with risk-based contracting under the upside risk-only MQISSP/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.

Independent Advocates' Alternative

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

Independent Advocates' Alternative

5. Not test downside risk with any <u>other</u> Connecticut populations unless and until its safety and effectiveness is established in other states.