

TO: Health Care Cabinet  
FROM: Sheila B. Amdur  
RE: Bailit Health Care proposal  
DATE: October 11, 2016

Thank you for the opportunity to speak with you today. As a member of MAPOC, I participated in the Bailit presentation of their proposal to the Health Care Cabinet. I have also followed closely the discussion among advocates regarding this proposal.

I fully understand concerns about consolidations in the health care industry and whether these consolidations contribute to significantly increased costs. However, I find the consultant's analysis and proposal to you severely lacking in examining:

- Very little emphasis on identifying high use, high cost patients and how their medical needs are addressed to improve quality of care and mitigate cost
- Very little emphasis on over-utilization of expensive diagnostic procedures
- No emphasis on Connecticut as a high cost state in terms of labor and doing business in the state
- Very little emphasis on social determinants of health which are major contributors to excess costs in health care
- Very little understanding of how the Medicaid population differs sharply in need and approaches needed to deliver health care effectively
- Almost no understanding of the extraordinary success the Connecticut Medicaid program has achieved in reducing costs, improving the quality of care, and improving patients' health care experience

It was also astonishing to me that the consultants did not appear to be familiar with the very extensive work that was done to develop a Health Neighborhood model targeted to people who are dually eligible for Medicare and Medicaid (that unfortunately the state did not implement, presumably because the state did not want to make the initial investment). This model had buy in from both consumers and providers, and was a shared saving model focusing on quality and then on cost savings.

I also was astonished to listen to the supposition that:

“Providers respond to risk of loss in a greater way than they do the possibility of reward.”

We certainly experienced this during the colossal failure to the risk based, capitated model the state previously used to “manage” Medicaid, which led to an explosion of costs in DCF of

institutional care as providers responded to risk by getting rid of the children who needed the most expensive care!

The models cited by the consultants are still in their infancy. Connecticut is already engaged in a focused, value and quality based approach in its Medicaid program. Let's not throw what we are successfully doing overboard, because there is a new shiny proposal that offers unproven outcomes! Let's also zero in on the reasons for why the costs of health care may be higher in Connecticut, and identify the causes before we try so-called "cost containment" models that have little proven validity.

Lastly, may I comment briefly on the issue of bringing all state agencies with any relationship to health care under one administrative umbrella. I have been involved in organizing health and behavioral health services, their administration, and policy development for 45 years. I keep thinking I am finally going to retire, until I see a proposal like this that revives the old standard of "rearranging the chairs on the Titanic model." DMHAS, DCF, DDS, DSS, and others have distinct populations and distinct responsibilities that require distinct methods of serving our most vulnerable populations. I suggested to the consultants that a much better model would be to examine where there is crossover of needs or "functionalities" that are common to the responsibilities of each of these Departments.

For example, under Governor Malloy's direction, the state is a national leader in ending chronic homelessness, because all state agencies involved in any way with providing housing or services to people in housing closely align their work as it is applied in communities. As a state we have undertaken similar initiatives related to reducing our prison populations. I would suggest that we examine where other inter-agency work, such as for the mushrooming addiction epidemic, could be undertaken. We already have an Office of Policy and Management that is charged with this kind of planning and coordination among different state agencies.

I realize the difficult task that you confront. But I would urge you to seriously consider the recommendations brought to you by the advocates and not repeat the mistakes of our past.

Thank you.