TO: Health Care Cabinet
FROM: Sheila B. Amdur, 49 Separatist Road, Storrs, CT 06268
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RE: Opposition to Preliminary Votes on Certain Cost Containment Proposals Affecting Medicaid
DATE: November 15, 2016

I could not come to the public hearing today, and have a few comments about the "Cost Containment" proposals you are considering in relation to Medicaid.

The recommendation to set up Consumer Care Organizations (CCOs) to move all Medicaid enrollees into downside risk (Proposal 1A) should be rejected.

This appears to be a theoretical, and not an evidence based approach, and one that I believe will lead to unintended consequences. We are already seeing consolidations in the health care provision and insurance markets, and as more demands for "cost efficiency" increase, the less likely that the very patient-centered approaches Connecticut has modeled will be able to survive. These future demands related to downside risk, competitive bidding in the market place, penalties for not meeting certain required outcomes—all in my humble opinion will lead to larger conglomerate horizontally and vertically integrated health care provision with less choice for consumers and decision making far removed from the delivery level.

Downside risk threatens harm to vulnerable Medicaid enrollees by removing the focus on quality outcomes that lead to better health and reducing the rate of growth of spending over time. The current PCMH program now covers 43% of Medicaid enrollees, bringing more providers into the Medicaid program, andd both coordinating care and resulting in lower ER usage. Why would we risk the success of this person-centered approach to care that is working?

The proposal for an all-payer Health Strategy Office with broad authority to implement aligned health care reform is of great concern.

- I have always distrusted concentration of authority and power in one super-agency, however that super-agency is constituted. I don't think "one size fits all," and especially in relationship to the complexity of the Medicaid population. As I indicated in earlier comments I gave to the Health Care Cabinet, there appears to be glossing of how the Medicaid population differs sharply in need and how approaches needed to deliver health care effectively are population, and often by sub-population, specific.
- We already have in place a governmental structure for focusing on cross agency initiatives, namely the Office of Policy and Management. If we need to strengthen their capacity to do focused planning on where there is crossover of needs or

"functionalities" that are common to the responsibilities of each of these Departments, then let's strengthen what already works.

Our Medicaid program has had made major strides in reducing per-capita costs by focusing on high need, high cost patients. Let's give the Medicaid agency the resources to zero in on other areas of high cost, and on improving our emphases on quality outcomes for consumers. Why change something that is working, especially in a political climate that is now totally uncertain.