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**Sent:** Wednesday, April 22, 2015 11:52 PM  
**To:** Stolz, Adam; Sklarsky, Katie; Alice Ferguson; Arnold DoRosario - Northeast Medical Group/Yale-New Haven Health [REDACTED]; Bonita Grubbs ; Christopher Borgstrom; Darcey Cobbs-Lomax - Project Access [REDACTED] Donald Stangler; Ellen Andrews - CT Health Policy Project [REDACTED] Gaye Hyre - ArtBra New Haven Cancer Survivors Group [REDACTED] Kristen Noelle Hatcher; Johanna Bell [REDACTED] Kate McEvoy; Katherine S. Yacavone - Southwest Community Health Center, Inc [REDACTED] Keith vom Eigen; Keith vom Eigen - Burgdorf Health Center [REDACTED] Linda Barry - Chief Operating Officer [REDACTED] Margaret Hynes; Maritza Bond - Eastern Area Health Education Center [REDACTED] Peter Bowers, MD; Robert Russo - Robert D. Russo MD and Associates Radiology [REDACTED] Robert Willig; Roy Lee [REDACTED] Victoria Veltri  
**Cc:** Deanna.Chaparro [REDACTED] Joe Dunn; Mark Schaefer [REDACTED] Moratti, Michelle; Richard Kehoe; Sullivan, Virginia; Dookh, Faina  
**Subject:** Public Comments RE: Materials for 4/23 EAC Meeting - Consolidated Comments & Presentation

Thanks, Adam, for including me on this correspondence and providing these documents.

I will mention this during the public comment as well, but I thought I should provide some alternative suggested language for the into sections of the report in advance, so folks can review exactly what I am proposing:

1. There is a disconnect between what the report is titled and what it is about. On page 36, it is noted that this report focuses on the primary charge of the Council and that is to develop methods to reduce patient selection and under-service and recommend a response to demonstrated such behavior, that is, to **prevent harm** from the imposition of shared savings under SIM. Although there is a third, vaguer, charge of the committee, and that is to define the plan to ensure certain at-risk groups “**benefit** from the proposed reforms,” that has not begun—that will be for a later phase. See page 7. Nevertheless, the report is entitled “Ensuring Connecticut’s Underserved and At-Risk Populations Benefit from SIM,” which is clearly not the subject of this report. I would say instead: “... Are Not Harmed by Shared Savings Under SIM.”
2. Similarly, the statements on pages 2 and 7 of the report suggesting that the over-arching role of the council “is to ensure that as SIM reforms are implemented, at risk and underserved populations benefit,” are not really accurate. While that would be very nice, of course, that is really a secondary issue for the council to look at, at a later phase. We do not want to lose sight of the major protective goal that motivated the creation of the council, and that is to avoid harm from the imposition of shared savings. So I would urge that the secondary goal of ensuring vulnerable groups “benefit” be identified as such on pages 2 and 7.
3. In two places, the report uses excessively conditional language about the reason for the enterprise: the “*possible potential* for adverse responses to financial incentives”- Pages 2 and 9. This contrasts with the definitive-sounding assumption that the fee for service system in fact has incentives which necessarily “lead to unnecessary provision of services” (page 8).

I would propose that, at a minimum, the word “possible” be removed in these two passages on pages 2 and 9.

4. While the report notes in the second paragraph on page 7 that for commercially insured populations, each payer will implement “its own distinct programs,” it does not note that the MQISSP for Medicaid populations must be developed by DSS under guidance of the MAPOC committee of cognizance, a matter of critical concern to advocates and state officials alike. I would urge that a sentence be added after the second sentence here, reading:

“The MQISSP will be developed and implemented by the Department of Social Services, the single state Medicaid agency, under the guidance of the Care Management Committee of the Council on Medical Assistance Program Oversight, in a manner consistent with the best interests of Medicaid enrollees, in accordance with the protocol between the PMO and DSS.”

Thank you for considering these comments now, with the understanding that I also will discuss them at the beginning of the meeting tomorrow evening.

Sheldon

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