From:	Sheldon Toubman
To:	"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]; McEvoy, Kate; 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]; Hynes, Margaret; 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]; Veltri, Victoria
Cc:	Chaparro, Deanna L; Schaefer, Mark C; Joe Dunn; Richard Kehoe; Stolz, Adam; Sullivan, Virginia; Moratti, Michelle
Subject:	Public Comment re This Evening"s Equity and Access Council Meeting
Date:	Thursday, May 07, 2015 12:00:40 PM

To: Equity and Access Council Members

Regretfully, I will not be able to attend this evening's meeting. However, I did want to provide public comment, as if I were there in person at the beginning of the meeting.

My specific concern is with the passage of the recommendation regarding where the shared savings go if a provider group produces savings but fails under the under-service measures, non-compliance with which results in forfeiture of those savings. The recommendation (#3.5) that, in this event, the money not go to the payer but instead go to corrective action plans and/or community health development is extremely important and should be adopted. While the suggestions for where the money should go are important, even more important is to ensure that the one-half of savings which would otherwise go the provider not go to the payer. The reason for this is straight-forward:

In the Council's discussions, it (including me, when I have participated) has primarily focused on the inherent incentives under shared savings which might encourage a provider, consciously or unconsciously, to stint on appropriate health care in order to maximize shared savings, ½ of which they get to keep. But we really haven't focused on the possible unintended incentives on payers to do the same. This is inherent for the one-half of savings they get to keep from what savings the providers reap, but at least it is clear that the providers are supposed to get no financial benefit if the savings are generated in inappropriate ways, to discourage this.

But if a provider who forfeits his savings because of inappropriate under-service nevertheless has that money go the payer instead, now the payer reaps DOUBLE the reward even if the money is saved in inappropriate ways, by restricting access to necessary care. And a payer could game the system to make this more likely: For example, it can establish burdensome prior authorization rules which dissuade providers from even asking for authorization for certain kinds of services, and then use the provision of those services as the under-service measure (without telling the provider, which the council has decided for other reasons to be the recommendation), so as to increase the chances that the savings going to the provider instead go to it. Prior authorization is already used by payers to save money in this fashion, often inappropriately, but, under the shared savings model, the providers as well can be enlisted through financial incentives to assist in propagating these kinds of inappropriate restrictions on access to care.

There are myriad other ways for payers to game the system so they can keep all of the shared

savings for themselves, regardless of how the money is saved. If they are at least limited to only ½ of the savings generated, this will help to reduce the under-service likely to be caused by payers gaming the system in this matter.

I realize that some of the payers have said that self-funded employers who use insurers as ASOs may object to this. However, every single thing being recommended by the Council is only a recommendation anyway, because there are no mechanisms to force any of the state or private (self-funded or otherwise) payers, except perhaps the ASOs for state employees, to apply **any** of them. Accordingly, if the word "Innovation" in "State Innovation Model" means anyway, the council should at least recommend what it thinks are the best policies for reducing the likelihood of inappropriate restrictions on access to care inherent under any total cost of care payment model such as shared savings. At least that will be the basis for a bully pulpit to encourage adoption of such a wise policy.

Accordingly, I urge the council to adopt this recommendation as a top priority.

Thank you.

Sheldon

Sheldon V. Toubman
New Haven Legal Assistance Association
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