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March 11, 2015

**Testimony of Sheldon Toubman in Support of HB 6938 (An Act Concerning The Delivery Of Quality Health Care And Modernization Of Health Care Facilities).**

Senator Gerratana, Rep. Ritter, and Members of the Public Health Committee:

Thank you for the opportunity to testify in support of this important bill.

My name is Sheldon Toubman and I am a staff attorney with New Haven Legal Assistance Association. I have represented Medicaid enrollees in all manner of health access issues for some 27 years. I am here today to testify in support of HB 6938. This bill would do two important things: (1) address a threatened loss of essential hospital services in the city of Waterbury and (2) redirect federal funding under the State Innovation Model (SIM) to this important cause and away from a problematic initiative which is threatening access to care for the vulnerable Medicaid population statewide.

To put this issue in context, Committee members need to know that Medicaid in Connecticut today is a success story, both in quality and access, and in cost control. Since we moved away from risk-based managed care organizations to a unitary non-risk administrative services organization with extensive use of patient-centered medical homes (PCMHs), more primary care providers are participating, and, unlike most states, our per-person Medicaid costs are under control-- in some cases, apparently unique in the country, showing **reductions in per member per month costs**. It is estimated that “bending the cost curve” for Medicaid has saved the state over \$400 million in the last two years.<sup>1</sup> This progress was only possible through collaborative, transparent efforts across stakeholder groups, especially the Council on Medical Assistance Program Oversight (MAPOC), which took the necessary time to develop effective strategies. This has led to better policymaking and has aligned stakeholders in working toward success for both consumers and taxpayers. Transparency and the engaging of all voices have been the keys to success.

A critical piece of this success has also been the broad use of PCMHs, which pay nationally certified medical home primary care providers extra for high quality care coordination, resulting in lower incidence of expensive crises. A third of Medicaid enrollees are now enrolled in PCMHs. The primary care providers get paid extra if they do well on consensus quality measures, not based directly on money saved but with that the likely result. And these providers have no financial incentive either to refer patients out for excessive treatment or to restrict such referrals—they act as neutral arbiters on the care their patients receive from other providers.

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<sup>1</sup> [http://www.cthealthpolicy.org/briefs/201502\\_governor\\_proposes\\_deep\\_medicaid\\_cuts.pdf](http://www.cthealthpolicy.org/briefs/201502_governor_proposes_deep_medicaid_cuts.pdf)

In sharp contrast, the SIM initiative, which first came to public light in the fall of 2013, has been characterized by top-down planning geared solely to obtain a moderately sized federal grant. Consumer and consumer advocate involvement was very late in coming, after all important design decisions had already been made. Even after consumers had been brought in to various councils, they have found that their decision-making can be, and is, unilaterally overruled by staff of the SIM Project Management Office which is running the initiative.

In addition, the central organizing assumption of the SIM initiative, as conceived by the PMO, is that there is an epidemic of expensive **over-treatment** happening throughout the state, under every payor, and the only way to combat this is to put direct financial incentives on treating providers so that they make more money by keeping down the total costs of care of their patients, through “shared savings.” Although the SIM designers tout the requirement that certain quality measures must be met in order for the providers to receive shared savings, the SIM initiative has been working to hold down the **number** of measures so that it would be fairly easy for providers to make more money by skimping on their own patients’ care, while still meeting the quality measures and thus profiting from shared savings.

Moreover, at least in the case of the Medicaid program, the central organizing assumption is not even accurate: the big problem for Medicaid enrollees, notwithstanding the significant gains since we replaced the MCOs, is that of **under-treatment** because there are too few of certain kinds of providers, particularly specialists. It is often difficult for Medicaid to even get an appointment to see one of these specialists. So the last thing they need is to have their own doctors have a new financial incentive to further restrict their access to care.

There are many well meaning individuals, including many consumer advocates, trying their best to minimize the harm from the SIM plan by constructively participating in planning councils, but the PMO is aggressively pushing for 1/3 of all Medicaid enrollees to be forced into this risk-based system by January 1, 2016, because that is what they wrote in the grant proposal to the federal government. A broad coalition of consumer advocates wrote to the Centers for Medicare and Medicaid Services in September of 2014 urging that, if they were going to approve the grant, they should slow down the forced move of all of these vulnerable individuals into shared savings, given that their primary problem is **lack** of access to needed services, not over-treatment, and that the Medicaid program is already headed on a very good fiscal trajectory. The advocates warned that there just was not sufficient time for the careful planning that would be needed to minimize harm for this group, with a January 1, 2016 date looming, and urged that shared savings first be rolled out with a less vulnerable population, and studied, before applying it to Medicaid.

Since then, advocates and, privately, some state officials concerned about the Medicaid population, have been urging that we slow down the move of Medicaid enrollees into shared savings to allow for a far more thoughtful process which can protect these enrollees, among other things, with carefully-developed under-service measures special to the Medicaid population. Unfortunately, the PMO will have none of this and is aggressively pushing to place about 250,000 vulnerable Medicaid enrollees into an un-tested system with financial incentives to further restrict their care on January 1st. In fact, we have learned that, to achieve this implementation date, the details and Request for Proposals for this plan must be completed in just seven weeks. This is despite a protocol negotiated between DSS and the PMO making clear that any decisions concerning Medicaid enrollees and SIM must be made in the “best interests”

of Medicaid recipients, as already provided in federal law, **not** the interests of other patients, payers or state agencies, or the dictates of a particular grant.

Given the problems with the SIM shared savings model, the lack of meaningful consumer involvement, and particularly the aggressive push to impose shared savings under SIM on a large percentage of Medicaid enrollees with inadequate planning, which is clearly not in their best interests, it fair to say that the SIM initiative, as currently conceived, has the potential to cause significant harm to the Medicaid program. Indeed, in the case of the Medicaid program, **SIM is a solution in search of a problem** that does not exist, which threatens that Connecticut success story.

On the other hand, the situation of the hospitals in Waterbury involves a critical access issue. A far more appropriate use of federal funds under SIM would be to redirect the SIM money toward developing a value-based health care system in that city, which can save its hospital resources. Therefore, I strongly support the provisions in HB 6938, which would require a study of redirecting SIM funds to solving that serious, real problem, rather than the invented one justifying inappropriate intervention in the successful Medicaid program.

Thank you for allowing me to testify before you today.