Via E-mail

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Commissioner Deidre Gifford
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We write to urge the Office of Health Strategy to reconsider its plans to pursue its health care cost containment program as currently formulated. We also urge the Department of Social Services to abandon its so-far failed experiment in shared savings through the PCMH+ program and put those resources in to expanding and strengthening the successful PCMH program. We believe the cost containment strategy and the continuation of PMCH+ is more likely to result in greater health disparities, and erect greater barriers to health care access, for Black and Latinx residents of Connecticut. Both plans seek to cut costs at the provider and payer level, but those savings are not passed on to patients who are Medicaid enrollees and do not pay premiums or cost sharing. More concerning, in order to achieve such cuts, providers and payers will be forced to cut services or access to low income patients, who will be unable to afford to pay out of pocket for denied services.

We understand that there is legitimate concern about the increase in the cost of health care. However, Connecticut's HUSKY program leads the nation and the state in controlling those costs, with average per member per month annual increases approximately 1.35% from SFY 2015 to SFY 2019,[i][1which is far below the general rate of inflation.

Objection to Cost Growth Benchmark Initiative

We note that cost is measured by the insurer, including the state in the case of Medicaid and Husky B, at the primary payer level. As such, any cost savings are unlikely to trickle down to the patient. Apart from a few HUSKY B enrollees, there are no premiums, copays or other cost sharing for Husky enrollees. Given this, HUSKY enrollees would not experience a financial gain from any cost savings in the way private enrollees in private insurance plans do. These privately insured enrollees might see a reduction in their premiums and cost-sharing, however; the savings may simply be retained as profits by commercial insurers and providers.

We fear, however, that while not benefiting consumers financially, there are many ways that a cost containment program could result in reduced access to health care, both in terms of physical access and the services provided. Such reductions in access could dramatically increase the well-documented health disparities between racial groups in Connecticut.

For example, a 2014 study of the largest U.S. metropolitan areas by the Pittsburgh Post-Gazette/Milwaukee Sentinel found that since the 1970, physicians and hospitals have been moving out of lower income areas, where the population is more likely to be sick, to wealthier areas.[ii] The 2016 Agency for Healthcare Research and Quality Disparities Report found that poor people experienced worse access to care compared to high-income people in 19 of 20 access measures, and black people had worse access than white people in 10 of 20 measures. In no measure did poor people or black people have better access than high-income people or white people.[iii] The proposed cost caps will reduce overall health spending and therefore access to critical specialty, hospital, and other care for such patients. Focusing on cost containment at the provider and payer level is more likely to exacerbate barriers to access than to alleviate them.

People without primary care providers rely on local clinics, which often suffer as a result of health care system consolidation and cost cutting. For example, in New Haven, the creation of the "primary consortium" of Yale New Haven Health, the Cornell Hill Health Center, and Fair Haven Community Health Care, the latter two FQHCs, and the location of the consortium in the YNHH Long Wharf facility moved three clinics in minority-majority residential neighborhoods to a location that is not only not a residential area, but is also not easily reachable by foot or public transit. Yale New Haven Health has proposed addressing the transportation issue by providing Uber rides, but local advocates have dismissed this arrangement as inadequate.[iv] At the same time, because FQHCs are required to be paid at higher rates for the same services provided to the same individuals, this new consortium, approved by OHS, will cause the Medicaid program to pay more for the same services, undermining the goal of cost control under the cost containment initiative.

The consolidation of the New Haven FQHCs illustrates the disconnect between cost savings at the institution level and cost at the patient level. Ignoring the higher required reimbursement under Medicaid for the same services when provided by FQHCs, and, assuming for the sake of argument that this arrangement is wildly efficient financially with the three clinics sharing administrative and overhead expenses, patients will face increase costs, depending on their local clinics. Getting to the clinic at a remote location will cost the patients, either for the cost of transportation or for the additional time required to travel to the new location. Patients may be discouraged from seeking care because of the difficulty in traveling to the clinic. Assuming for the sake of argument that the number of appointments available is not reduced by this consolidation (although this seems highly unlikely), patients may have difficulty making appointments with their provider or will have to go through their history with a new provider each visit.

These impacts will disproportionately fall on racial and ethnic minorities, who make up 62.99% of the patient population of FQHCs nationally.[v] Black and African Americans specifically make up 21.69% of the patient population. One in four people in poverty relies on FQHCs, as compared to 0.6% of people with incomes more than twice the federal poverty level.[vi] Limitations to access to FQHCs will also directly impact access to health care for Medicaid recipients as more than 17% of Medicaid recipients receive care at an FQHC.[vii] These patterns hold true in Connecticut, with 50% of patients at state FQHCs identifying as Hispanic/Latino and 24% identifying as African American.[viii]

Finally, while we believe that HUSKY should not be a part of any general cost containment initiative by OHS, we note that, as many other advocates and providers have already pointed out, attempting to

implement any cost growth cap in the midst of a pandemic, with grossly altered medical expenditures, is inappropriate. The state's providers are reeling from the impact of COVID-19, with high costs related to actual COVID patients and extra infection control measures, at the same time that other health care usage has dramatically dropped, resulting in artificially depressed expenditures and revenue for providers. For example, the Community Health Network reported at the September 10 MAPOC meeting, "FQHC, Medical billing and billing by other practitioners such as physician assistants and nurse practitioners, decreased by 28.7% in Q2 of 2020 compared with the same period in 2019."[ix] While Connecticut has significant difficulty in accessing relevant data, whatever current data is available is going to be greatly skewed as a result of excessively depressed use of non-COVID health care, and thus not a basis for any rational cost containment calculation based on current expenditures, as intended.

Given the success of cost control of Medicaid in Connecticut, HUSKY should not be the target of this cost containment program, and indeed, if the program is to proceed at all, HUSKY should be excluded from the benchmarking project. Unfortunately, the state has little leverage in controlling the costs of health care paid for through private insurance, apart from negotiating the insurance plans for state employees. Thus, HUSKY, which the state *does* control, is the most likely program to be enlisted as the state's laboratory guinea pig for this benchmark experiment, with inappropriate savings extracted from this already very efficient program credited to the overall all-payer cost reduction goal to the benefit of hard-to-control private insurers, giving a false appearance of overall success.

Objection to Continuation of PCMH+ Program

Connecticut is not alone in struggling to contain costs, and it is unfortunately not alone in trying to contain those costs by targeting Medicaid programs. The District of Columbia has proposed a move to enroll all its Medicaid beneficiaries in a managed care program, a move that has been overwhelmingly objected to by its council members and local providers because of its likely result of reducing health care access and coverage for the city's poorest and sickest residents.[x]

The move to expand enrollment in PMCH+ in Connecticut is similar to DC's latest action, which forces those Medicaid patients receiving fee-for-service care into managed care plans. Connecticut's move to enroll all HUSKY beneficiaries into PCMH+ is a step toward enrolling everyone in a program built upon the risk-based managed care model that the state wisely rejected in 2012. As with the cost containment strategy, the fundamental premise of PCMH+ is to incentivize cost reduction at the provider level. "Shared savings" looks only at the costs incurred by the provider and borne by the payer. Because Medicaid programs do not impose direct monetary costs on enrollees, which are the only costs counted in PCMH+, indirect costs and non-monetary costs incurred by enrollees do not factor into the accounting for the program.

The serious result is that, under PCMH+, any reductions in access, increased wait times, and reduced services are not computed in the "costs" incurred. The state has tried to account for these potential costs for enrollees through very limited quality measures, but these measures only account for the outcome of treatment provided, not the difficulties enrollees have in getting the treatment. Indeed, most patients will not even know if services are being restricted to generate savings for the provider because they will not be told about what is **not** being offered or prescribed (the notices sent to enrollees enrolled in the program failed to include mention of the financial incentives for providers to reduce total of care for their own patients and therefore to be sure to ask providers if any other treatments might be available).

We fully appreciate the importance of measuring healthcare outcomes—after all, the most important goal of a healthcare policy is a healthy community. If PCMH+ demonstrated the improved outcomes promised when it was first unveiled, we would be fully supportive of the program and its expansion. However, that is not the case. PCMH+ has performed no better, and in several instances worse, than PCMH. There is no data that supports the notion that shared savings will result in improved health outcomes, which is unsurprising given how little the two paradigms have in common. Ironically, PCMH models have been found to have lower per patient costs with better outcomes than hybrid models like PCMH+.[xi] We urge the state to end the PCMH+ program and instead devote resources to expanding the successful PCMH model which rewards outcomes which show providers are helping their patients achieve better health outcomes, such as fewer emergency department visits, fewer hospital admissions, shorter hospital stays, etc.

We applaud the efforts of OHS to make health care more affordable for the residents of Connecticut, but we request that OHS not do so at the expense of those least able to afford increases in costs for accessing healthcare, whether direct or indirect through reduced access to care incentivized by cost caps. And we urge DSS to terminate the PCMH+ program and exclude HUSKY programs from any cost containment plan that may move forward.

Sincerely,

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