Updated January 3, 2022

From: Ellen Andrews, PhD, CT Health Policy Project
To: Tina Hyde, CT Office of Health Strategy, Tina.Hyde@ct.gov
Re: Public comment on Roadmap for Strengthening and Sustaining Primary Care

Thank you for the Office of Health Strategy's (OHS) solicitation of public comment on your Primary Care Roadmap. These comments follow my letter of November 15, 2021 voicing concerns; I look forward to OHS's reply. In an October 22, 2021 letter, twenty five independent advocates and providers, including the CT Health Policy Project, voiced serious concerns which have been ignored in the current draft. The independent advocates, including the CT Health Policy Project, renew our offer to work with OHS to improve Connecticut's primary care system.

Since 1999, the CT Health Policy Project has worked to improve access to high quality, affordable healthcare for every state resident. As a nonpartisan nonprofit organization, we have fought to improve access to better care that is affordable and sustainable for Medicaid members, uninsured state residents, employers, taxpayers, and consumers.

Recognizing that primary care is foundational to a healthy and efficient healthcare system, we have been strong supporters of improving and strengthening Connecticut's primary care system. We raised concerns to OHS's failed forerunner to the current Roadmap, under the State Innovation Model (SIM) project that prompted concerns from advocates and providers, here and here, and from legislators.

We have many concerns with the Roadmap, as envisioned by OHS.

- OHS's arbitrary decision to double primary care spending, **costing Connecticut's health system $3.9 billion** annually,[1] while limiting overall healthcare spending invites unintended consequences.
- The Roadmap ignores and undermines current initiatives in Connecticut that are improving primary care access and quality.
- The Roadmap pushes practices into primary care capitation, a failed payment model with serious risks to patients.
- The process to develop the Roadmap was driven by primary care physicians and missed critical independent consumer-related input.

[1] Calculation from CMS National Health Expenditures, CT total healthcare spending, trends and projections with OHS estimate, Primary Care Subgroup 11/16/2021 meeting, that in 2019 primary care was 5.3% of total spending – compares 2025 vs. 2019 primary care spending

- The Roadmap promotes a corporate, medical model to provide social and behavioral health services, undermining evidence-based, person-centered community care models that work.
- The Roadmap could worsen Connecticut's health disparities.

OHS's arbitrary decision to double primary care spending while limiting overall healthcare spending invites unintended consequences. As described in the advocates' letter, the choice to focus on the percent of total healthcare spending devoted to primary care is puzzling. **The Roadmap's increase in primary care spending will cost Connecticut's healthcare system $3.9 billion in 2025.**[2] While high-performing areas tend to spend more on primary care, correlation is not causation. Evidence on the best routes to develop a high-performing primary care system focus on practice supports, care management, evidence-based medicine, and data, which will likely increase spending but targeted to the right places.

Healthcare in Connecticut is much more costly than the rest of the US. In dollars spent, Connecticut's primary care spending is likely well above other states. According to the Primary Care Collaborative, Connecticut only lags other states in primary care spending when using a narrow definition that is limited to services delivered by only some primary care providers. However, Connecticut is 32% above the US average using a broad definition of primary care spending that includes services delivered by Nurse Practitioners, Physician Assistants, Geriatricians, and Gynecologists who are trained and licensed to provide that care. This broader definition respects patients' choices of providers.

Connecticut residents have far better access to primary care than most Americans. Primary care providers per capita, across definitions and roles, are up to 47% higher in Connecticut than the US average. Five out of six Connecticut adults report that they have a personal relationship with a doctor/healthcare provider, ranking Connecticut tenth best in among states. While there is undoubtedly room for improvement, from the patient perspective, there is little evidence of an urgent need to double resources in primary care, causing sacrifice in other areas and risking patient care.

Distrust in health policymaking is very high in Connecticut, including among primary care physicians. Policymakers in states with successful reforms have earned high levels of trust due to transparent and inclusive policymaking processes, adequate data and analytic capacity, and the political will to act on the information to improve care. Connecticut has none of these.

The Roadmap ignores and undermines current initiatives in Connecticut that are improving primary care access and quality.
Unlike other states with successful reforms, Connecticut has no meaningful system, history, or political will to monitor for underservice, cherry-picking, or other potential harms to patients of

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primary care capitation. Without monitoring, we would not know if disparities grew, patients are being forced into urgent care or emergency rooms, if outcomes are worsening, if access to specialists is even tighter, or if costs are rising. Our blind spots are vast.

Some primary care physicians have complained to OHS about the burden of completing the very successful, evidence-based Patient Centered Medical Home (PCMH) certification, to access higher payment rates. In the past, Medicaid has rejected primary care provider lobbying to lower standards for patient care. But this time, in response, OHS and their consultants have decided to create a new, weaker, OHS-run certification process that relies heavily on provider self- attestation for those practices that cannot or choose not to meet independent national standards[3]. There is overwhelming evidence that the current PCMH recognition program by independent, national accreditation sources such as NCQA, is associated with better health outcomes, improved access to care, higher quality, improved provider satisfaction, and lower costs. All of the Roadmap's core functions are reflected in NCQA's PCMH certification standards.[4] NCQA requires verification of these functions with specific criteria. All other states and insurers use these gold standard PCMH standards to verify meaningful transformation and that payers are getting value for our money. NCQA certification has served Connecticut's HUSKY program extremely well, saving billions of taxpayer dollars while attracting critical providers to the program that covers one in four state residents.

We are deeply concerned about the risk to patient care of a weaker, undefined alternative set of standards driven by the physicians that would be held accountable and paid under the certification.

OHS's plan to monitor for harm under the Roadmap and primary care capitation is extremely weak. OHS plans to track less than half the measures DSS tracks in their controversial PCMH Plus shared savings plan, and mainly process metrics rather than tracking health outcomes. Under this plan, OHS would be very unlikely to identify any harms when they happen. Broad outcome measures included in PCMH Plus and Medicare monitoring, such as avoidable emergency room visits and hospital admissions, are not included in OHS's proposed plan. Unlike PCMH Plus, OHS has no plans for a control group, allowing providers cited under even the meager monitoring plan to blame an influence of outside factors. Potential harms to patients from OHS's weak underservice monitoring include serious mental health problems, missing substance abuse and poor outcomes, reductions in quality of life due to loss of home health and other supportive care, loss of medication management causing dangerous interactions and other safety concerns, and poor birth outcomes. It is highly unlikely that OHS's proposal would detect much underservice. It is important to remember that the lack of evidence, is not evidence that there is no underservice.

Many independent observers, including several members of OHS's primary care committee that developed the Roadmap, have expressed serious concerns about OHS's ability and capacity to

[3] Roadmap, p. 9., OHS Primary Care Subgroup meeting, June 22, 2021.
[4] Roadmap, p. 7 – 8.

responsibly implement the Roadmap and primary care capitation without harming patients. If implemented, the Roadmap would be a massive expansion of OHS's scope and authority over healthcare in Connecticut, to include certification of practices, learning collaboratives, training, monitoring, enforcement, and evaluation. OHS has a troubled history in implementing similar reforms, effectively engaging stakeholders, regulating providers to protect underserved communities, protecting patients' privacy in medical records, developing a quality monitoring system, developing a functional APCD, and the previous attempt at primary care capitation under SIM.

The Roadmap pushes practices into primary care capitation, a failed payment model with serious risks to patients.

OHS has been very consistent in advocating for primary care capitation over the years and is clearly using the Roadmap to encourage it again.[5] Despite acknowledging the potential harm to patients due to underservice and stinting on care, and the inability to risk adjust based on social needs, OHS continues to push primary care capitation.

As outlined in the advocates' letter to OHS, Medicare has experimented with primary care capitation extensively over the last decade. Evaluations of their programs have found little or no improvement in quality and no savings to the program. Since rejecting capitated managed care in 2012, Connecticut's Medicaid program ,which covers about one in four state residents, has saved billions in tax dollars, expanded access to care, improved quality and providers have come back to the program.

In addition to its failures in savings and quality improvement, primary care capitation creates serious risks for patients and payers including underservice and stinting on critical care, strengthened incentives to refer patients out to more costly specialists, and incentives to expand primary care patient panels to unsafe levels. While the Roadmap recommends risk adjusting capitation rates based on medical need, social needs are ignored, denying critical resources to patients in need and incentivizing primary care providers to avoid patients with social needs. As Connecticut learned when HUSKY was run through capitated managed care organizations, data access and quality suffer. As providers are paid whether patients receive care or not, capitated models provide less transparency and accountability on care delivery.

Responding to primary care physicians' concerns about sufficient revenues under capitation, the current version of the Roadmap makes primary care capitation a voluntary option for providers[6], but not so for patients. There is no provision for consumers to opt-out of the risky model.

The success of any payment model hinges on robust monitoring, accountability, transparency, and the political will to make difficult and unpopular revisions as necessary. Well-managed fee-for-service is serving Connecticut's Medicaid program very well. Since leaving the capitation

[5] Roadmap. P. 13.
[6] Roadmap, p. 10.

model almost ten years ago, HUSKY members have benefitted from better access to well-coordinated, high-quality care with a cost control record among the best in the nation. The key to HUSKY's success has been monitoring, following the evidence, and adjusting the program as needed in an open policymaking process that engages all stakeholders.

Advocates remain concerned about a return to capitation in HUSKY. New leadership at DSS has been very involved in development of the Roadmap and Appendix B of the Roadmap includes three pages comparing Medicaid's flawed PCMH Plus program and the Roadmap.

The process to develop the Roadmap was driven by primary care physicians and missed critical independent consumer-related input.

Contrary to OHS's assertion, the process to develop the Roadmap was not inclusive. Twenty one of the twenty-five members (86%) of OHS's committee that developed the Roadmap represent either providers or payers. The committee is dominated by primary care physicians and their needs.

> Roadmap goals -- "First . . . While primary care clinicians are considered the bedrock of the health care delivery system, primary care physicians are among the lowest compensated physicians." (Roadmap, p.1)

The first goal[7] outlined in the Roadmap is to increase primary care physicians' incomes. Primary care physicians are very well compensated compared to critical healthcare provider and other occupations in Connecticut. OHS only solicited Connecticut primary care organizations to assess the need.[8] Other sources have different perspectives on workforce needs to support primary care. It is troubling that the focus of OHS's primary care planning appears to be accommodating primary care physicians rather than patients and consumers who pay the bills. OHS's consultants acknowledged at their October 26, 2021 meeting that the purpose of OHS's primary care efforts is to increase spending on primary care, not to expand services.

OHS gave their committee only evidence supporting capitation as a payment model to support primary care and nothing that described its failures or the risks to patients. As outlined in the advocates' letter, well before OHS's committee began considering the question, OHS announced in a national webinar that Connecticut will implement primary care capitation. This replicates the flawed process OHS followed in the failed SIM initiative.

In 2019, in response to a request from the Governor's office asking for better alternatives to OHS/SIM's controversial plan, the CT Health Policy Project published a report with 49 options to improve primary care in our state. The options, large and small, came from a search of the literature, interviews with primary care physicians, nurse practitioners, physician assistants, residents, health system administrators, payers, state officials, and experts at the national level and from other states. We received no feedback to our report but reiterate our offer to work with policymakers to support Connecticut's primary care system.

[7] Roadmap, p. 1.
[8] Roadmap, p.1.

The lack of an inclusive, evidence-based, and balanced process not only results in failed policies but also wastes time, resources, and opportunities, as well as further undermining trust for future reforms.

The Roadmap promotes a corporate, medical model to provide social services, undermining evidence-based, person-centered community care models that work.
The absence of critical input from independent, thoughtful stakeholders and over-representation by primary care physicians has led OHS's committee to design a model that medicalizes non-medical issues. We are very concerned about placing primary care providers in control as the lead in "whole-person care" to include behavioral health and social needs. Under OHS's model, community resource and behavioral healthcare access will be coordinated and directed by primary care practice care managers, rather than the community organizations providing those services. Mental health and community service needs are very personal, in a way that medical care may not be. A good match between patients and behavioral health and community care providers, in culture, location, language, race/ethnicity, gender, or other characteristics, is critical to successful treatment. Patients' needs, not large health systems' corporate relationships, must drive choice of behavioral health and community service providers. Some primary care physicians on the committee have wisely raised concerns about their capacity to responsibly meet these added responsibilities for non-medical care.

The Roadmap could worsen Connecticut's health disparities.
As communities of color, women, seniors, people with disabilities, and other underserved populations are the most likely to lack necessary care, OHS's lack of monitoring and evaluation will hide inevitable harms to these communities and widen Connecticut's already large health disparities. OHS's plan to lower total health care spending simultaneously with $3.9 billion annual increases in primary care spending, will only heighten the risks of primary care capitation to health equity.

Because the Roadmap's payment model does not include risk adjustment for social needs, patients who do not speak English, are without housing or transportation, food insecurity, are not able to afford care they need, face the stressors of living in poverty, or live in unsafe environments, would not receive the resources needed to improve their health. These social risks fall hardest on Black and brown communities. OHS and their consultants have argued that social risk adjustment methodologies are not yet reliable. Respectfully, it is only responsible to wait until they are reliable to ensure no harm is done.

The CT Health Policy Project urges OHS to work with independent advocates and other excluded stakeholders to improve Connecticut's primary care system and not risk harm to underserved communities, vulnerable patients, and the consumers, employers, taxpayers, and patients who pay the bills. We look forward to hearing from you and working together to improve the health of every Connecticut resident.