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January 10, 2022

Ms. Tina (Kumar) Hyde
Manager of External Affairs, Communications, & Legislative Liaison
Connecticut Office of Health Strategy (OHS)

Dear Tina,

Thank you for sharing the draft primary care roadmap with some legislators. I have had a chance to review the document. I agree with the dire need to invest in a sustainable investment strategy in primary care health.

The first listed priority was the affordability of healthcare. I would not have had that on the top of the list, although it is of value. I appreciate recognizing the burnout of primary care physicians and fewer individuals choosing to be in the primary care fields. I also understand that there is recognition that the primary care infrastructure of the State needs interventions.

There are areas in the draft policy, which may need further conversations, discussions, and possible interventions. I want to start by identifying some of those.

We must invest in the education of the next generation of primary care physicians. It is important to note that after four years of medical school, most primary care physicians invest in at least three years of education, providing them the capacity to make sure that they can manage and have comprehensive strategies on patient management. As I am involved in training medical students and residents, some of these physicians will graduate from medical school with debt in the range of $350,000.

I am concerned that the strategy for sustainability does not include increasing the number of positions for physician training in the State. It is also important to note that I do not see opportunities for loan repayment plans and investment to keep the workforce trained for excellence and care in the State mentioned; I would consider these priorities.

I felt those patient advocates for chronic illnesses were not part of the group in the stakeholder group. It appeared to be very heavily leaning toward larger provider-based groups, but they may not necessarily have the entire market share of primary care services. For example, the Federally Qualified Health Care Centers provide care to a large segment of our vulnerable population. It would have been helpful to have a significant element of them at the table.

Also, the Connecticut State Medical Society was not a part of the medical societies in the stakeholder group, at least based on the report.

The fact that this strategy focuses on creating teams for various functions automatically makes way for individual physicians, who have historically been managing patient care, to become less relevant and less able to participate. I also noticed that the practice teams do not designate a physician as a lead. It is essential to recognize medical education, and its value is critical. We need family practice and internal medicine to train individuals who have spent thousands of hours to get to the point of leading teams. This method results in less relevance for primary care physicians, who have managed patient care and provided excellence throughout the history of medical teams in Connecticut and the United States. This strategy also removes the relevance of the trained physicians either working alone or in teams.

The payment methods focus on providing reports, which obviously increases the overhead for any group of practice and takes away from focusing on the management of the patient, rather than documentation of that management to get reasonable payment. Furthermore, the payment model parameters are based on the historical system that the payors had created, which has led to the current weaknesses in the primary care infrastructure. This results in a heavy-handed approach that the payors have used in our State, which has resulted in trained physicians leaving the State or the next generation choosing not to move towards investing in the excellence of training and care.

The future risk-adjusted payments are not necessarily on medical complexity as much as on patient social and overall complexity and time spent by the physicians and the team members. The monitoring practices used by the payors and Medicaid have resulted in erosion of the existing infrastructure. It appears that the current strategy is essentially doubling down on the rules that have eroded primary care infrastructure.

The draft document does not have periodic checks on the policies' impact. There are no checks and balances mentioned.

I appreciate that the practices can choose to continue receiving FFS payments instead of opting for a value-based approach to prospective care. In addition, I understand that community health workers have value within certain parts of our State and specific communities.

I know many hours have been spent addressing a very complex process in an ever-changing and complex environment. I want to thank all the stakeholders who did come to the table and the OHS team members who put it together with limited resources. I am willing to have a detailed conversation with you about some of my concerns and appreciate the amount of time spent to get to this draft report; I feel that there are areas of opportunity for enhancing this further. Thank you again for taking the time to read my comments regarding this.

Sincerely,

Senator Saud Anwar
3rd District