Connecticut Health Policy Project

Better, safer ideas to support primary care in Connecticut

Primary care is the foundation of the health system. It is, or should be, patients' first interaction with the healthcare system for non-urgent issues. There is strong evidence that care coordination linked to primary care practices, such as patient-centered medical homes (PCMHs), foster improved health while lowering costs.[i] Areas with more primary care capacity enjoy better health outcomes, better access to services, and lower hospitalizations and emergency department visits, even after controlling for sociodemographic and lifestyle factors. Individual Americans connected to a primary care provider (PCP) for their usual source of care have better health outcomes.[ii]

While Connecticut is among the healthiest states in the nation, we have some challenges, particularly for underserved populations. Concerns have been raised about inadequate future primary care capacity. Primary care providers in Connecticut report severe stress on their finances, ability to practice and quality of life. Meaningless administrative burdens and lack of payment for critical aspects of care are common. Practices report great difficulty recruiting primary care providers. **To address primary care's challenges, the state SIM (State Innovation Model) plan has proposed to capitate primary care in Connecticut**.[iii] The proposal is to pay a set fee per patient for primary care services regardless of need and to make primary care practices financially responsible for social and medical problems beyond primary care. While there is good evidence that care teams coordinating services and adding new technologies and capacities to primary care practices can help many patients, it is not the only option to support primary care or to improve health. Moreover, there is no evidence that placing primary care providers at financial risk for that coordination or for improving care beyond their control is effective.

Capitation was widely deployed across Connecticut's health system in the 1990s and 2000s with the goals of lowering costs and improving access to care. Unfortunately, it achieved neither goal and has been abandoned. Seven years ago, Connecticut Medicaid was a mess. It was run by overpaid, unaccountable insurance companies. Providers wouldn't participate in the program so members were forced into emergency rooms for simple, avoidable conditions. **Since rejecting capitated managed care in 2012, Connecticut's Medicaid program** which covers almost one in four state residents, has **saved billions in tax dollars, expanded access to care, and improved quality and providers have come back to the program through managed fee for service**.[iv]

Persistent concerns with SIM's primary care capitation plans have been raised by advocates, consumers, providers, policymakers, and others. **In addition to capitation's past failure in Connecticut, new concerns** include incentives to inappropriately deny

necessary care (underservice), to cherry pick lucrative patients (adverse selection), and to accelerate healthcare costs.

Evidence-based social and associated clinical services have great potential to improve the quality of life, prevent and manage disease, while controlling health costs. It is also clear that support and information from primary care providers can facilitate access to those services for some patients. However, **it is not clear that requiring connection through primary care to access those services is always the best option for every consumer**.

- A growing number of Connecticut primary care practices are joining large health systems for a variety of business reasons. **Having only one option for care, chosen by large health systems for their own corporate reasons, reduces consumer choice and quality.** Consumers who prefer services, often for sensitive issues, based on geography, cultural appropriateness, unique qualifications of providers, faith-based preferences, or other qualities may not have access to the best option for their needs, potentially limiting effectiveness. Alternatively, if payers including the state, endorsed a diverse set of consumer options for those services that met standards based on only quality, safety and effectiveness, consumers could choose the option that is most likely to work for them.
- If the state and other payers directly paid for evidence-based services, **the state and other payers would collect all the savings**, rather than sharing with large health systems.
- Retaining fee-for-service billing allows for **better accountability and monitoring** through better data. Because providers do not need to bill for services to get paid under capitation, data and information about who receives what services, and the outcomes, is often missing. Since shifting from capitation back to managed fee-for-service, Connecticut's Medicaid program has a single source of consistent data, allowing far better program monitoring and planning.

Better options

It's important in any reform to **let PCPs focus on providing primary care**, the core of healthcare, as they were trained. Let other healthcare and social service providers do their jobs as well. Be sure there are two-way connections between providers and that consumers have choices.

Supporting primary care does not require new provider-risk payment models. All the innovations described below can be implemented in the current fee-for-service environment; none require provider risk payment models. In fact, in the large majority of cases, they can be more easily, more quickly and more efficiently implemented in the current fee-for-service system.

Connections and Population Health

- Create a system to track where patients receive services -- to keep care to one source, allow coordination, eliminate gaps and duplication
    - Can link through payers' systems, even if they are not paying for some services

    - Promotes better communication between all providers caring for patients, both medical and social services,
- Make integrated Electronic Health Records (EHRs) a requirement for licensing
- Allow practices to share resources, including support and care management staff, and clinical information to benefit patients and lower costs
- Get a functional Health Information Exchange working that connects all of Connecticut's health landscape (finally)
    - Allow providers to share information on patients they are treating so practices can work together easily and reduce contradictory information or treatments
    - Allow information sharing across all practices, including small practices, and remove barriers between large health systems and other practices and systems
- Develop the All-Payer Claims Database (APCD)
    - Provide useful reports back to PCPs on their panels, with user friendly analytics, across all payers
    - Link reports to best practices they may be missing and resources to improve
- Support development of local Community Care Teams[v]
    - To address social determinants of health, high-cost/high-need community members, public health and safety risks, clinical and social service needs and capacity across communities and populations
    - Not to share revenues, which would change the focus and culture of the collaboration
    - Potentially to include specialized resources for specific conditions or populations
    - Link to APCD reports on capacity for the area
    - Ensure robust participation of practicing PCPs and primary care administrative staff with meeting times and formats (online vs. in person) that fit their needs
    - Link to hospital and local public health needs assessment planning
- Require retail clinics and urgent care centers to connect to patients' PCPs, share treatments, prescriptions, referrals, lab results
    - Clinic must alert payer of patients not attributed to a PCP
    - If not insured, refer to Access Health CT
    - Follow up to ensure they are connected

Care Coordination

- Reward PCPs or other care team members for conversations with patients about treatment options including medications, to discuss consumer costs, side effects, and the goals of each treatment/medication to help patients afford as much of their care as possible, prioritize if they can't afford everything and understand the risks if they can't. Rather than allow self-reports by providers, survey patients to ensure effective conversations happen. If patients don't remember the conversation or it wasn't clear, it won't be effective.[vi]
- Develop a network for primary care practices of reliable referrals to include social services, nutrition, behavioral health, fitness, healthy food, screening programs, etc.

    - Create a public registry with details on services offered, consumer ratings, payers accepted for providers, etc.
    - Allow consumers to choose among community service providers
    - Require tracking of referrals both ways, and meaningful connections of other providers with PCPs and the care team
    - Track increases in demand for community services and modify resources as needed to maintain capacity
- Create standards for person-centered care planning across payers
    - See Complex Care Committee recommendations[vii]
    - Use to identify gaps in care and overtreatment for individuals
    - Ensure consumers approve the plan and get a copy of it
    - Collect, aggregate and analyze care plan information for needs assessment and capacity planning
- Ask patients to list all their care managers/navigators/care sites
    - Have the patient choose one person to be the lead on their care across payers and providers
    - Ensure patients and caregivers have clear contact information through multiple means (phone, email, text, etc.) for identified, individualized care managers independent of payers
    - Give the consumer's chosen lead care manager the authority and the ability to connect and coordinate care, according to patient's preferences and PCP recommendations
- Cancel Rx – allow consumers to request cancellation of medications
    - With follow up by prescriber, care management lead

Communications – providers, patients

- Provide consumers with balanced materials on chronic illnesses
    - Either identify trusted sources, independent of conflicted interests, or develop them with PCPs
    - Give trustworthy sources for more information
    - Use as the basis for shared decision-making
    - Distribute through primary care practices, integrate with the care plan
- Require CMS's informed consent standards[viii] for procedures, inpatient and outpatient
- Ensure all patient notices are consumer-friendly, include the reason for the notice, ability to opt-out, an independent place to call or email if they have questions, middle school reading level or lower, and links to more information
    - Especially for new payment models
- Create a state-wide patient education campaign, including:
    - Patient-centered medical homes – don't go to the ER for small things, communicate with your PCP
    - Why you need to show up for your appointment or cancel it, explain the financial burden of no shows on providers and the impact on care including double booking and longer wait times
    - Make very clear to patients the expectations for their care and their rights and responsibilities
    - Standards for care planning and how to participate to create a realistic plan they will comply with

    - Don't ignore health problems and delay care; if a treatment didn't work, call the office
    - Options include orientation statements and videos, phone prompts, mailed reminders, automatic appointments, patient contracts, connecting to new messengers including social service and community organizations, and sharing best practices

Operations, administrative burdens

- Implement and pay for new technologies and practice methods to lower PCP and consumer burdens and time loss
    - Phone, text, video and secure email communications for check in, connected to EHRs and clinical systems, to reduce disruption and costly, unnecessary trips to the office
    - eConsults, telehealth (with standards) for both consumers and PCPs
    - Remote monitoring when appropriate
    - Ensure new technologies are voluntary for practices. Not all are appropriate or helpful for every setting or PCP's practice
    - Reflect savings to the system and revenue loss to practices in higher PCP payment rates; provide upfront payments to cover investments (with standards)
- Lower administrative burdens on PCPs[ix]
    - Set caps for EHR and other system provider alerts/red flags -- too often they are almost constant, making them useless
    - Set caps on paperwork/report time burdens for all PCPs
    - Sample and audit alerts, paperwork/reports, and other PCP administrative burdens. If any go over a reasonable standard for any PCP, escalate to clinical leadership for reducing case load. Follow up to ensure the solution fixes the problem
    - Evaluate and streamline operational processes[x] including claims processing, payers' provider relations/communications, credentialing, prior authorization, and eligibility verification to eliminate senseless administrative burdens
    - Pay claims within 30 days
    - Create EHR-integratable database for patient-specific information on covered treatments, prior authorization requirements, in-network panels, formularies/step therapy, consumer costs for care (including deductibles) and total prices so PCPs can have informed conversations about treatment options with patients
- Integrate best practice prompts into EHRs, use AI tools
- Ensure all consumers have no-cost access to their medical records in a format compatible with all EHR systems
    - Payers should provide and encourage independent options for second opinions
- Make getting answers to questions easy for PCPs
    - Create a state ombudsman for PCPs independent of payers – to find resources, file a report, licensure, get services for a patient, etc.
    - Online resources, but also have access to humans who can answer questions when needed without waiting hours on the phone
    - Measure for quick, accurate responses and effective follow up

- Performance withhold in ombudsman contracts based on provider feedback

Finances

- Equalize primary and specialty care payment rates
  - Add to office visit rate to reflect critical services such as counselling on risky behaviors and other time-consuming but currently unreimbursed care
  - Pay for evidence-based nontraditional services such as communications with patients beyond face-to-face office visits, home visits, and care coordination
- Equalize payments for behavioral health care to ensure sufficient resources for referrals
- Tie PCP rate increases to accountability, in place of pay for performance, shared savings, capitation, and other parts of the confusing, fragmented mosaic of healthcare payments
  - Balance accountability for performance outcomes with the realities of practice and what PCPs can/should control, respecting consumer decisions
  - Increase payments at common interest rates if bills are not paid quickly
- Do not pay based on outcomes or other metrics outside PCP control
  - This leads to resentment, gaming of the system and diverts effort away from essential primary care
  - Hold-backs on payments are also deeply resented by PCPs and add to the financial uncertainty in running primary care practices
- PCPs interviewed for this paper were clear that they are not opposed, even welcome, taking on issues beyond medical services such as addressing social determinants of health, educational achievement for children, and community safety, but object to being paid based on these performance issues
  - Primary care practices value and welcome serving as resource referrals and providing educational materials.
  - However, anything that is added to the fifteen-minute office visit displaces something else
  - They have no control over other systems responsible for these issues
  - Non-health professionals are not typically paid based on people's health outcomes
- Consider non-financial incentives [xi] which are often more salient for professionals

Services

- Implement and pay for home visiting when appropriate with the patient's consent, allow patients to choose who comes to their home and what organization they work for; offer diverse options including culturally diverse, geographic, and other relevant preferences. Visits should be informed by and provide feedback to the clinical team
- Expand medication management
  - Allow consumers to choose who provides this service
  - Connect the results of the service back to the PCP and the medical record, with details about patient preferences and how decisions were made

    - Implement evidence-based drug therapy support programs and supports
- Support behavioral health integration with primary care but also ensure independent options as well
    - Some consumers do not want to access behavioral health care where they see their doctors, or from large health systems
    - That cannot be the barrier to getting care for mental health or substance abuse problems
- Remove barriers to end-of-life conversations, palliative and hospice care

Workforce and Practice

- Maximize scope of practice laws for nurse practitioners, physician assistants and other primary care team members to ensure every team member is working at the top of their training
    - Expand payer adoption of payment for non-physician providers
- Maximize use of school-based health centers, ensuring they are connected to PCPs/PCMHs and clinical records are integrated. Do not be prescriptive about how connections happen
- Set humane hours of work for residents and PCPs with robust and escalating penalties for repeated violation
    - Do not ease back standards after attention eases
    - Audit and enforce hours
    - For patient safety, effective practice, similar to other fields e.g. pilots, and PCP quality of life
- Expand continuing education opportunities about evidence-based care for all PCPs
- Strengthen Community Health Worker (CHW) proposed standards to ensure professionalism and effectiveness
    - Like all other health professionals, licensing should not be voluntary for payment or practice
    - Create an independent assessment/testing for licensure, especially independent of ties to CHW schools in Connecticut
    - Have CHW, academic and clinical experts from outside Connecticut who do not work for CHW schools evaluate and revise proposed standards
    - Remove the requirement that CHWs must be trained in a Connecticut school
    - Focus training on integration with the clinical team and supervision by clinical staff
    - Ensure all CHW practice in Connecticut requires integration with clinical teams; do not allow independent practice, providing "medical" support to patients without strong integration with the clinical team
    - Robust monitoring and evaluation of this new workforce to ensure cost effectiveness
    - Make licensure provisional until practitioners prove effective practice over time
- Primary care provider student loan forgiveness/scholarships
- Increase Connecticut residency slots, supplement federal funding with state support

Policy development and changes

- Minimize program changes for PCPs including when policies need to change, group them in time, ensure clear communication with adequate lead time before changes are effective, provide resources for more information and to resolve transition issues, and, most importantly, explain why the policy is changing and what the goal of the change is
- Routinely get input from practicing, real world PCPs and administrative staff for all state policy changes, big and small
    - Get input in provider-friendly ways – electronic, evening/early morning meetings, local/regional
    - Have regular meetings of practicing, real world PCPs with policymakers and payers
    - To avoid unintended consequences or increased burdens

The CT Policy Project wishes to thank the many practicing primary care providers, consumers, advocates and others who took the time to review this proposal. It is far better for your feedback.

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[i] Patient-Centered Medical Home (PCMH), NCQA, https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/, accessed April 17, 2019

[ii] L Shi, Impact of Primary Care: A Focused Review, Scientifica, 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/; B Stanfield, et. al., Contribution of Primary Care to Health Systems and Health, Millbank Quarterly, 2005, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/

[iii] Primary Care Modernization: Unlocking the Potential of Primary Care to Improve Health and Affordability,

[iv] Seven Years Later Connecticut Medicaid Still Saving Taxpayers Money, CT Health Policy Project, February 2019, https://cthealthpolicy.org/index.php/2019/02/18/seven-years-later-connecticut-medicaid-still-saving-taxpayers-money/

[v] https://www.cga.ct.gov/ph/BHPOC/OP/related/20150101_2015/20151106/Community%20Care%20Teams.pdf

[vi] A minority of physicians talk to patients about the cost of medications they are prescribing. Physicians rate the cost of medications as the least important factor to discuss with patients. But 88% of Connecticut residents regularly taking prescriptions are worried about their ability to afford them. Half are cutting back on pills, skipping doses or not filling a prescription due to cost. Thirty five percent of Americans regularly taking drugs have never had their medications reviewed by a provider to see if they can stop any. But when they do have conversations, most often providers can suggest a less expensive alternative. (Pharmacy Education Committee recommendations, CT Healthcare Cabinet, July 2018)

[vii] Care plan best practice recommendations to DSS, MAPOC Complex Care Committee, January 2018, https://www.cga.ct.gov/med/committees/med2/2018/0126/20180126ATTACH_Care%20Plan%20Best%20Practices%20-%20final.pdf

[viii] CMS Finalizes Important Patient-Friendly Informed Consent Payment Proposal, CT Health Policy Project, August 2017, https://cthealthpolicy.org/index.php/2017/08/29/cms-finalizes-important-patient-friendly-informed-consent-payment-proposal/

[ix] 31 Ways to Save on Healthcare in Connecticut's Budget, CT Health Policy Project, June 2018, https://cthealthpolicy.org/index.php/2018/06/26/31-ways-to-save-on-healthcare-in-connecticuts-budget/

[x] Fixing Medicaid: Healing Connecticut's Largest Healthcare Program, CT Health Policy Project, May 2011, http://cthealthpolicy.org/wp-content/uploads/2011/05/201105_fixing_medicaid-1.pdf

[xi] Provider Incentives: Thinking Beyond Financial Rewards and Penalties, Commonwealth Fund, September 2014, https://www.commonwealthfund.org/blog/2014/provider-incentives-thinking-beyond-financial-rewards-and-penalties