October 22, 2021

Victoria Veltri, Director of the Office of Health Strategy
P.O. Box 340308
450 Capitol Avenue MS#51OHS
Hartford CT 06134-0308
Via email

Dear Ms. Veltri:

We write as independent consumer advocates to share our serious concerns with the Office of Health Strategy's (OHS) plan to shift all primary care in Connecticut to a capitated payment model, also known as "prospective payment" (and previously known under the inaccurate term "bundled payment"). Our concerns echo advocates' and legislators' past letters opposing your office's similar plan under the State Innovation Model (SIM) planning process to capitate primary care. We have three broad concerns— (1) that the model is deeply flawed and, despite enormous effort, has not worked in other states, (2) that Connecticut particularly may not need to, and is not positioned to, be successful in capitating primary care, and (3) that the process used by your office and consultants, similar to OHS's top-down processes under SIM, was designed to arrive at this pre-determined outcome. We also disagree with the assertion that the COVID-19 pandemic makes clear that capitation is the only way to support primary care.

Using a broad definition of primary care, Connecticut residents have better access to primary care than most Americans and our state already spends more on primary care services than most states. We are concerned that primary care capitation could jeopardize the access to care this represents as well as create challenges in accessing other critical care. There are other, better tested ideas to improve primary care without risk to patients or payers.

Primary care capitation is a flawed model that does not work. 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. It is important to note that the Medicare experiments were all voluntary, which attracts practices and health systems that are the most likely to succeed.

Many concerns with the model have been raised in the literature and by Connecticut stakeholders.

- Primary care capitation, like all provider financial risk models, can **lead to underservice, or "stinting" on appropriate, necessary care,** because providers make more money by providing or prescribing **less** care.
- Since primary care providers do not receive any direct payment for providing office visits under this model, primary care capitation **strengthens incentives to refer patients out to specialists** and other providers for problems that could be addressed by primary care. This practice increases total healthcare costs, harms continuity of care, and undermines the benefits of primary care.

- As providers are paid a set fee per patient, whether or not they provide care, primary care capitation provides an **incentive to expand patient panels beyond capacity**. Patients who need care may not be able to get an appointment, leading to more underservice and over-referrals.
- Primary care capitation also incentivizes providers to avoid patients with complex medical problems which may require more visits than usual, leading to adverse selection/cherry-picking of patients and **exacerbation of Connecticut's serious health disparities**. People with significant disabilities and Black and brown people, who have higher incidence of complex medical conditions, are at particular risk.
- **Risk adjustment,** designed to mitigate this kind of adverse selection, **is an inexact science** and routinely ignores the significant influence of social determinants of health.
- While capitation *allows* practices to innovate and the flexibility to personalize care with their own resources, as does traditional fee-for-service payment, there is no requirement that they do so, nor is there a mechanism to support, encourage, or monitor for it. **In the past, capitation did not foster innovation in Connecticut**. Practices can use their funds now under fee-for-service, and often do, for innovations such as Community Health Workers, telehealth, group visits, and care management. Our current Medicaid program includes all these innovations and more in a very successful fee-for-service, care management-focused model.
- As Connecticut learned with Medicaid Managed Care Organizations in the past, **capitated models provide less transparency and accountability**. As providers are paid a set fee for each patient, rather than paid for each claim, they have no incentive to collect or share data on what care is actually delivered to which patients. **This could also exacerbate Connecticut's wide healthcare disparities.**

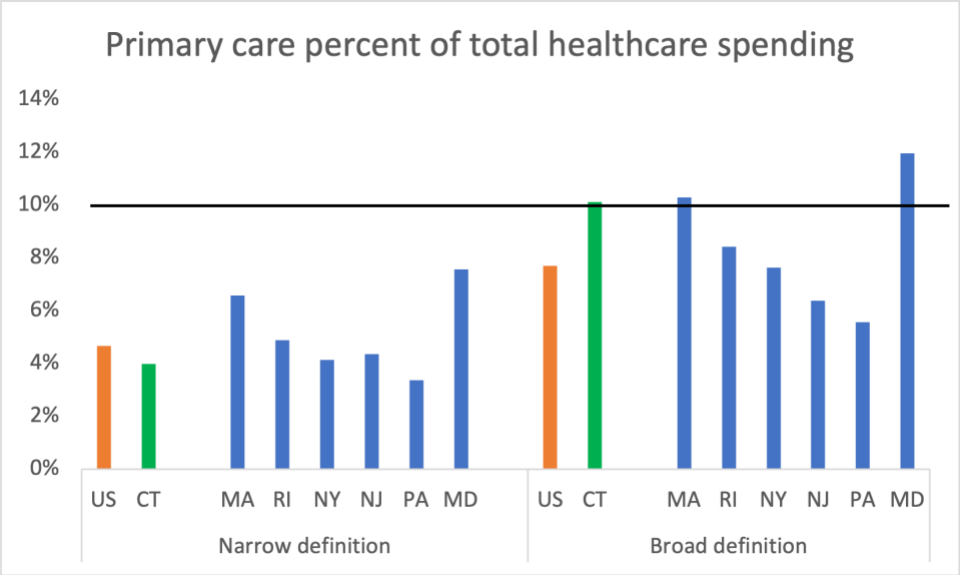
Primary care capitation may not be needed and will not work particularly in Connecticut

Unlike other states with successful reforms, Connecticut has serious challenges that make primary care capitation even riskier for patients, consumers, and payers. Distrust in policymaking is very high in Connecticut, including among primary care physicians. Other states have high levels of trust due to transparent and inclusive policymaking processes, data and analytic capacity, and the political will to act on the information to improve care. Connecticut has no meaningful system, history, or political will to monitor for underservice, cherry-picking, or other potential harms of new payment models. Our blind spots are vast. Without widespread trust in Connecticut healthcare policymaking, improved capacity, and transparency, a model as already risky as primary care capitation is even less likely to succeed. OHS would better serve reform efforts by addressing these deficits first.

The argument for primary care capitation in Connecticut specifically is premised upon a provision in the Governor's Executive Order No. 5 to devote a higher percentage of health care dollars to primary care. But imposing such arbitrary limits will only worsen the ill effects of primary care capitation.

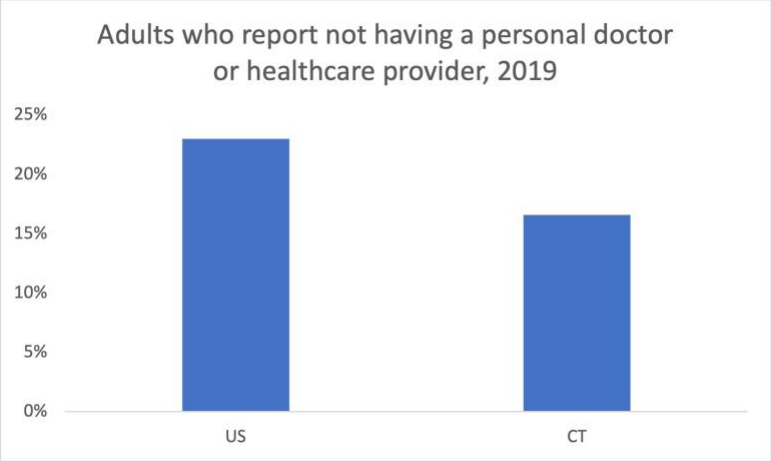
First, there has been no foundation laid for OHS's initiative to double the share of spending on primary care in Connecticut. The choice to focus on the percent of total healthcare spending devoted to primary care is puzzling. While high-performing areas tend to spend more on primary care, correlation is not causation. Evidence on the best routes to developing a high-performing primary care system do not include increasing funding, but rather focus on practice supports, care management, evidence-based medicine, and data.

As Connecticut spends more in total than most states on healthcare per capita, largely because of high prices, it is not clear that the percent of spending on primary care is a good indicator of a robust health system. According to the Primary Care Collaborative, even by that measure Connecticut only lags other states when using a narrow definition that is limited to services delivered by some primary care physicians. 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 recognizes patients' choices about which providers they prefer to receive care from. Using this patient-centered definition, Connecticut is already above the 10% target set by Executive Order No. 5 that governs OHS's primary care efforts.



Source: Primary Care Spending: High Stakes, Low Investment, Primary Care Collaborative, December 2020, https://www.pcpcc.org/resource/evidence2020

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 have a personal relationship with a doctor/healthcare provider, ranking Connecticut tenth best among states.



Source: BRFSS, https://www.cdc.gov/brfss/brfssprevalence/index.html

Thus, given Connecticut's relative success with emphasizing primary care, the imposition of arbitrary minimum percentage expenditures for this care is not needed here. But tied to the overarching proposal to capitate primary care, these arbitrary minimums will give primary care providers more of the limited health care dollars while simultaneously strongly incentivizing them to unnecessarily refer patients out to specialists -- who will in turn be given **less** of those health care dollars. Together, these two proposals will actually make access to primary care in the state worse, not better.

OHS's process to choose primary care capitation was pre-determined and missed critical input

OHS's intention to move all Connecticut primary care to capitation was announced on a national webinar **months before** the OHS's Primary Care Subgroup committee considering how to structure or restructure payment to support primary care[1] began deliberating on that question. In any event, OHS's new committee to address primary care reform was mainly populated by members of the prior SIM committee that previously endorsed primary care capitation. The committee has only been given information that supports primary care capitation and **none** of the substantial evidence that it hasn't worked elsewhere.

OHS's new committee is dominated by primary care physicians. Their needs are driving decision-making on the recommendations. As one example, some primary care physicians have complained about the burden of completing NCQA's very successful, independent, evidence-based patient-centered medical home certification, to access higher payment rates. In response, OHS and their consultants have decided[2] to create a vague, new, state-run certification process that relies heavily on self-attestation. Providers will receive the higher

[1] State Cost Growth Benchmarking Models: Understanding and Addressing Health Care Cost Growth, Manatt, June 17, 2021, https://www.manatt.com/insights/webinars/state-cost-growth-benchmarking-models
[2] OHS Primary Care Subgroup meeting, June 22, 2021.

payment rates just by indicating an *intention* to become certified within a timeframe open to change by request to OHS.

The absence of critical input from independent, thoughtful stakeholders and the over-representation by primary care physicians has led OHS's committee to design a model that medicalizes non-medical issues. The model subsumes behavioral health and substance abuse care within primary care practices. Under the model, community resource access will be coordinated and directed by primary care practice care managers, rather than the community organizations providing those services. Some primary care physicians on the committee have wisely raised concerns about their capacity to meet these added responsibilities for non-medical care.

The lesson of COVID-19 is not that primary care should be capitated

The recent pandemic severely impacted revenues for primary care practices in Connecticut. As patients delayed accessing preventive care and care to manage chronic conditions, primary care practices could not bill for services. These practices were not alone. Many other important industries were also severely impacted by COVID, from dentists' offices to cleaning services. In addition to healthcare-specific subsidies, primary care practices had access to, and took advantage of, the same government subsidies as other industries. If we need to do more to keep critical primary care practices solvent, we should invest in them, but with accountability and time-limited measures to address the specific public health emergency. Capitation and its harms, on the other hand, would be forever.

Capitation could have alleviated practices' revenue losses in this pandemic, but the same is true of every other industry. Yet there are no calls to regularly make monthly payments to them indefinitely just in case of another pandemic, as suggested for primary care providers. The next crisis may overwhelm primary care practices, rather than reducing office visits. In that event, we should expect to hear calls for higher reimbursements and potentially a return to fee-for-service. In addition, during the COVID-19 pandemic, if we had paid primary care practices when patients didn't come in for care, while also paying more to hospitals and other providers hard hit by COVID, overall healthcare spending in Connecticut would have been much higher in 2020, driving up premiums and costs to taxpayers.

While Connecticut's fee-for-service model has drawbacks, they can be addressed more safely with monitoring and smarter incentives to support better outcomes, such as under CT Medicaid's successful PCMH (no "+") model. Primary care capitation will only create new issues and is very unlikely to address our existing problems.

We urge OHS to work with advocates and other stakeholders to improve the current system and not risk harm to underserved communities by using primary care capitation. We look forward to hearing from you and working together to improve the health of every Connecticut resident.

Sincerely,

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CT Health Policy Project

Win Evarts
The ARC of Connecticut

Shirley Girouard, RN
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Connecticut Cross Disability Lifespan Alliance

Sheldon Toubman, Deborah Dorfman
Disability Rights Connecticut

Sharon Heddle
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