Connecticut Health Policy Project

November 15, 2021

Victoria Veltri, Director of the Office of Health Strategy
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Hartford CT 06134-0308
Via email

Dear Ms. Veltri:

Thank you for your thoughtful response to the October 22, 2021, independent advocates' sign on letter with concerns about the Office of Health Strategy's plans for primary care reform. Your response to our offer to work together to improve the health of every Connecticut resident is very welcome. In that spirit, I'd like to clarify a few misunderstandings of our concerns, highlight concerns from our letter that weren't addressed, and differ with some of your points.

While your draft Roadmap for Strengthening and Sustaining Primary Care released November 10, 2021, recommends making primary care capitation voluntary for practices, it would not be voluntary for patients. There is no provision for patients to opt-out of capitation. You do not acknowledge the risks to patients and other concerns raised in our letter.

Clarify misunderstandings

Our letter was not an endorsement of the current fee-for-service, nor was it a rejection of that model. The success of any payment model hinges on robust monitoring, accountability, transparency, and the political will to make hard revisions as necessary. You level some serious criticisms at fee-for-service without evidence, which, in some cases, may be deserved. But well-managed fee-for-service is serving Connecticut's Medicaid program very well. Since leaving the capitation model almost ten years ago, our HUSKY program provides improved access to well-coordinated, high-quality care with a cost control record among the best in the nation, saving taxpayers billions of dollars. The key to HUSKY's success has been monitoring, following the evidence, and revising the program as needed in an open policymaking process that engages all stakeholders.

Our letter also did not state, or even suggest, that Connecticut has invested "generously" in primary care. You are correct that we take issue with an arbitrary primary care spending target. We remain deeply concerned that doubling primary care spending, while constraining overall healthcare spending, risks limitations to specialty and other critical care. This is a special concern for Connecticut residents who rely heavily on the healthcare system, including seniors, people with disabilities, people with chronic conditions, the underserved, and Black and brown communities that have struggled to access necessary care.

I am troubled by your featured concern in this area that "primary care pay is significantly below that of specialist physicians". Primary care physicians are very well compensated compared to other critical occupations in Connecticut. I am troubled that the focus of your primary care planning appears to be accommodating primary care physicians rather than patients and consumers.

Differences on your points

Your assertion that capitation (mislabeled prospective payment) is not flawed and has worked in other states is unsupported. You don't address Medicare's poor experience with primary care capitation for 1.7 million members over six years that did not save money and had little or no impact on quality. The Capital District Physicians Health Plan from upstate New York slides that you shared are interesting, but they cover far fewer members and contains little detail on their model or an evaluation of the results comparable to Medicare's. As a physician-led organization, one of CDPHP's three main goals is to "significantly increase primary care physician income." It is not clear how Connecticut's primary care plan could replicate CDPHP's results and avoid Medicare's failures.

Only Rhode Island, from your list of other states planning primary care payment reform, has had time to evaluate their progress. Unlike Connecticut, Rhode Island has built on a long history of successful reforms designed and implemented by exceptional policymakers. Also unlike Connecticut, Rhode Island enjoys a strong foundation of trust among stakeholders because of a collaborative, evidence-based policymaking tradition. Trust is the foundation of any successful progress.

You outline service options and flexibility that could be implemented under a capitated payment model. These include expanded care teams, care coordination with social needs, new care modalities that are not tied to office visits, extended hours, and incentives to focus on prevention and wellness. But you fail to note that all these services can be and are supported in the fee-for-service environment, especially with per member set care management payments. Indeed, they are all features of HUSKY's non-capitated successful person-centered medical home (PCMH) program that includes all certified PCMHs in the state but one.[i]

You state that your Roadmap includes "parameters to protect patients from the risks and adverse impacts" outlined in our letter. Thank you for acknowledging capitation's potential to encourage practices "taking on more patients than they can realistically care for, resulting in limited appointment availability, potential under-service, adverse selection of patients, and practices directing patients to unnecessary utilization of specialist and emergency care." However, your proposed protections are exceptionally weak. They are weaker even than the inadequate protections in HUSKY's PCMH Plus plan. Primary Care Subgroup members have raised serious concerns about the vagueness of your Roadmap's monitoring plan.

While not referenced, there is evidence to support your assertion that well-functioning health systems devote more resources to primary care. However, correlation is not causation. As we stated in our letter, those well-functioning systems did not begin with increased funding but focused first on practice supports, care management, evidence-based medicine, and data. Increased funding did not lead, but followed, those improvements, ensuring that scarce resources were devoted to improving patient care.

Your response highlights the strong influence of primary care definitions in measuring primary care spending levels. In the definition you chose, narrow by your own description, Connecticut spends 5.5% of total healthcare costs on primary care. In contrast, the more inclusive definition we cite in our letter, finds that Connecticut spends over 10% on primary care, well above the US average.

In our letter, we chose to focus on patient access to primary care rather than the more variable spending metric. As we stated in our letter, "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 among states."

The 25 independent advocates, providers, and organizations who signed our letter disagrees with your assertion that the Roadmap planning process has been inclusive. This is a perennial problem with OHS planning. In the past, public comment to OHS/SIM committees has been ignored and mischaracterized. It is not surprising that few advocates give public comment, choosing other routes to share our voices. Your process diverges from the usual course of Connecticut policymaking which engages diverse stakeholders appointed by bipartisan legislative and administrative leaders. Your process, going back to the State Innovation Model, has resulted in unsupported, failed policies as well as further undermining trust, wasting time, and precious planning resources.

In your letter you acknowledge recommending a "state-developed recognition program" alternative to successful, nationally recognized primary care/PCMH certifications that includes self-attestation. The advocates' letter lays out our concerns 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. My students do not write their own exam questions.

We reiterate our concern about placing primary care as the lead in "whole-person care" covering physical, mental, and social needs. Physicians and health systems are not trained nor are they always the best entity to guide patients' choices for non-medical care. Patient preferences such as culture, language, race/ethnicity, or gender of providers can be critical to effective treatment. This is especially true for mental health, substance abuse, and women's health care. For some patients, the primary care practice may be involved in other care, but the choice of service providers should always be decided by patients, not by physicians or large health systems with corporate interests.

Concerns from our letter that aren't addressed

Your response to our letter neglected to address several important concerns.

- Concerns that raising primary care's share of healthcare spending will reduce access to critical specialty and other care
- Primary care capitation's potential to widen health disparities
- Potential hazards of risk adjustment, especially for underserved communities
- That capitation in Connecticut did not foster innovative care modalities
- Capitation's problems with transparency and accountability, as practices are paid whether or not patients receive care and providers no longer must file claims to be paid
- The very high level of distrust across Connecticut's healthcare landscape, and your Roadmap's contribution to that problem by accommodating primary care physicians and excluding other voices
- No evidence supporting the 10% primary care spending goal, and your chosen primary care definitions
- Better metrics of the health of Connecticut's primary care that rely on access to care
- That COVID does not necessitate primary care capitation

There may be a problem with access to primary care in Connecticut, but the nature of the problem is not clear, and your proposed solutions are not well targeted to solve problems. Advocates are eager to work with your office to find evidence-based, targeted solutions to the problem, rather than diverting scarce healthcare resources to physicians and practices without evidence of where the investment is needed, and without robust monitoring and a plan to adjust as needed.

Independent advocates are hopeful that your response to our letter signals an interest in engaging with diverse stakeholders to improve healthcare for every Connecticut resident. We remain eager to work with your office.

Respectfully,

Ellen M Andrews

Ellen Andrews, PhD

cc: Governor Ned Lamont
Senators Martin Looney and Kevin Kelly
Representatives Matt Ritter and Vincent Candelora
Commissioner Deidre S. Gifford

Commissioner Manisha Juthani
Commissioner Andrew N. Mais
Ted Doolittle, Office of the Healthcare Advocate
Members, OHS Primary Care Subgroup

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[i] CHNCT report to MAPOC Care Management Committee, November 10, 2021.