



Via Electronic Email

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Re: Connecticut Office of Health Strategy Roadmap for Strengthening and Sustaining Primary Care

Dear Ms. Andrews, et al.,

Thank you for your letter regarding the Office of Health Strategy (OHS) Roadmap for Strengthening and Sustaining Primary Care (“Roadmap”) in Connecticut. OHS’ Roadmap directly supports Governor Lamont’s priority for supporting the state’s primary care infrastructure, as highlighted in his January 2020 Executive Order Number 5. OHS’ Roadmap includes actionable steps to enable more effective, efficient, and equitable primary care that will enhance access, better meet the needs of patients and sustain primary care professionals.

The premise of your letter seems to be that the existing fee-for-service (FFS) payment system is the optimal one for providing sustainable, high quality primary care. The decades-long national movement to explore alternative payment models is driven by a clear understanding that FFS payments have limitations in promoting effective care coordination, care management, care innovation, integrated behavioral healthcare, preventive care, and quality improvement. It is for these reasons that OHS' Primary Care Roadmap – created to improve the structure and provision of primary care services and create higher quality, more equitable care in our state – includes a voluntary non-FFS payment model option. The Roadmap leaves open the possibility of other aligned alternative payment models should practices and payers identify additional models that will promote high quality and equitable primary care.

Further, I wish to correct several factually incorrect statements within your letter. First, your statement that OHS plans to shift all primary care in Connecticut to a capitated model is untrue. The purpose of the Roadmap is to lay out strategies to improve primary care delivery and effect payment transformation. The Roadmap includes common parameters for primary care payment and the provision of a voluntary payment model option that providers may select in addition to the existing FFS model.

I also wish to respond to broad concerns expressed within your letter – (1) that prospective payment is deeply flawed and has not worked in other states, (2) that Connecticut invests generously in primary care, and (3) that OHS' Roadmap process was designed to arrive at a pre-determined outcome.

Leading national organizations endorse prospective payment for primary care and other states support and use prospective payment to support primary care transformation

Prospective payment for primary care has been the normative primary care payment model in California for decades and is not viewed there as a failure. It is also a commonly adopted payment model in other regional markets. For example, in New York, Capital District Physicians Health Plan implemented a program over a decade ago and has published evaluation findings demonstrating how its integrated prospective payment model and patient-centered medical program has produced impressive results.ⁱ

Primary care prospective payment in 2021 is far different than what it was when first tried decades ago.ⁱⁱ Several leading national organizations now support use of prospective payment, in part or in full, as a model to sustain and improve our nation's vulnerable primary care foundation. Such organizations include the National Academy of Medicine,ⁱⁱⁱ CMS,^{iv} the Primary Care Collaborative^v and the Milbank Memorial Fund.

In addition, several other states supporting primary care transformation and payment reform programs are including prospective payment. Rhode Island,^{vi} Colorado,^{vii} and Washington^{viii} are just three examples.

A number of primary care practices and others have expressed interest in payment models that give practices greater flexibility to (1) use and sustain an expanded care team, including community health workers, pharmacists, nutritionists and other clinicians, (2) deliver and

coordinate care for medical and social needs, (3) use care modalities that are not often compensated under the FFS model, and (4) not have reimbursement tied to physician office visits. Patients also benefit from these types of improvements in primary care in the following ways:

- Practices have more time and attention for individual patients most in need of it, including patient education.
- Different care modalities provide the convenience of various types of appointments with increased access to the practice.
- An expanded care team is more equipped to provide a whole-person care approach to address a patient's physical, mental, and social needs, including use of community health workers and care coordinators whose role is in part to help address social needs through linkages and coordination with social services and other community resources.
- Improved collaboration across care providers results in early identification and intervention.
- Increased focus on prevention and wellness, rather than solely on treatment, improves health and reduces illness burden.
- Extended hours may allow increased access to care in primary care settings rather than other settings, like emergency departments.

Many Connecticut primary care organizations see these benefits, which is why they have conveyed to OHS their interest in access to a prospective payment model.

Finally, in response to your critique, the payment models under consideration by the OHS Primary Care Subgroup include parameters to protect patients from the risks and adverse impacts you mention in your letter, such as 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. The Roadmap's payment model parameters include quality incentives using measures that are aligned across insurers to improve the likelihood that practices will focus on highest priority quality and equity improvement opportunities and achieve improved performance for their patients.

Connecticut does not invest generously in primary care and must promote efforts to help primary care professionals better meet the needs of their patients, including with increased payments and flexible payment models

While touching upon several topics, most of the argument in your letter under the heading, "Primary Care capitation may not be needed and will not work particularly in Connecticut" criticizes the primary care spend target established by Governor Lamont in Executive Order Number 5.

By all accounts, primary care practices in Connecticut are struggling, especially our many independent practices. OHS has heard repeatedly from practices about great difficulty in hiring new clinicians. In addition, primary care pay is significantly below that of specialist physicians, making it difficult to attract new physicians to primary care. Finally, we know that other health

systems that invest more in primary care relative to specialty care have much better results in patient experience, cost and quality.

In your letter, you state, “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.” The report you cite is limited for the following reasons:

1. it includes spending on nurses, nurse practitioners and physician assistants irrespective of whether they practiced primary care or not, and most do not;
2. it includes spending on OB/GYNs, who *do* deliver some primary care services, but are trained as surgeons and who primarily do not deliver primary care, and
3. it utilizes MEPS data which are derived from a survey of patients and providers, and do not represent actual spending data in contrast to the analysis performed by OHS.

Contrary to your letter, Connecticut does *not* invest generously in primary care, and has not achieved its 10% target. OHS’ own calculation finds that only 5.5% of total spending in 2019 went to primary care clinicians for primary care services. This was calculated with data directly from payers, indicating that as a state Connecticut does not come close to the 10% benchmark set by the Governor. While Medicaid was close to the target in 2019 at 9.4%, in the commercial market the percentage was only 5.1%.^{ix}

OHS’ Roadmap process has been inclusive and informed by multiple rounds of stakeholder input, and has engaged consumers and consumer advocates

Before initiating work on the Roadmap, OHS sought input on the Roadmap process and strategies for strengthening and sustaining primary care from a wide array of stakeholders in addition to those represented on the Primary Care Subgroup. It was the feedback and input received through these discussions that framed OHS’ approach. OHS has continued this engagement with a broad group of stakeholders on an ongoing basis throughout the development of the Roadmap, as well as offered a public comment period during each of its Subgroup meetings, to ensure the recommended strategies were both desirable and feasible. The process has been inclusive and heavily informed by stakeholder input.

Your letter suggests that OHS is creating a state-run certification process that relies heavily on self-attestation. This, too, is inaccurate. The Primary Care Subgroup weighed the pros and cons of multiple options for primary care practices seeking enhanced payments and to become “OHS-recognized.” The Primary Care Subgroup ultimately recommended to OHS a hybrid option that includes a state-developed recognition program with some limited elements of self-attestation. OHS’ Roadmap proposes to recognize any primary care practice that demonstrates it is already recognized by NCQA as a patient-centered medical home. Other primary care practices seeking OHS recognition will have to demonstrate, to OHS’ satisfaction, mastery of 11 advanced primary care functions. Practices must also demonstrate their capabilities on a regular basis.

Your letter also raises concerns that OHS has designed a model that “medicalizes non-medical issues.” New definitions of primary care support a whole-person care approach that address a patient’s physical, mental, and social needs. OHS heard the various perspectives of the primary care physicians and others on the Primary Care Subgroup who ultimately supported the primary care functions in their final state. These functions do require coordination across the continuum of care, including connecting patients with community supports to address social risk factors (which includes community-based organizations that provide such services). This level of coordination is in line with what is expected of high-performing primary care practices.

If Connecticut wishes to protect, improve and sustain its primary care infrastructure, it must help Connecticut’s dedicated primary care professionals better meet the needs of their patients. OHS welcomes the continued collaboration with advocates and other stakeholders to advance this mission.

Respectfully,

Victoria Veltri, JD, LLM
Executive Director
Connecticut Office of Health Strategy

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

ⁱ http://www.ehcca.com/presentations/medhomesummit6/wood_ms2.pdf

ⁱⁱ <https://www.milbank.org/publications/prospective-payment-for-primary-care-lessons-for-future-models/>

ⁱⁱⁱ National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press.
<https://doi.org/10.17226/25983>

^{iv} <https://innovation.cms.gov/innovation-models/primary-care-first-model-options>

^v <https://www.pcpc.org/topic-page/payment-reform>

^{vi} <https://www.milbank.org/news/rhode-islands-updated-affordability-standards-to-support-behavioral-health-and-alternative-payment-models/>

^{vii} <https://drive.google.com/file/d/1Ug-npJYAqZk0R4A2IMTsKWm1uQYucMnk/view>

viii <https://www.hca.wa.gov/assets/WA-PC-model-for-Public-Comment-7-13-2020.pdf>

ix <https://portal.ct.gov/-/media/OHS/Primary-Care-and-Community-Health-Reforms/Primary-Care-Subgroup/2021-Meetings/10-26-21/PC-Subgroup-Presentation-2021-10-26.pdf>