Frequently Asked Questions about OHS's Primary Care Proposal

January 3, 2022

Connecticut's Office of Health Strategy has developed a Primary Care Roadmap to support primary care in Connecticut. OHS is accepting public comment on the draft Roadmap until the close of business Friday, January 14th. To send comments, email Tina.Hyde@ct.gov and put "Primary Care Roadmap" in the subject line. You should get an email receipt that your comments were received. Comments submitted by the CT Health Policy Project are here.

What is the problem the Roadmap seeks to solve?

According to the Roadmap, the goals are:

First, "increased investment in primary care. While primary care clinicians are considered the bedrock of the health care delivery system, primary care physicians are among the lowest compensated physicians". **The Roadmap's increase in primary care spending will cost Connecticut's healthcare system $3.9 billion in 2025.**[1]

Second, "action is required to expand the primary care workforce. Connecticut primary care organizations report staff shortages and enormous difficulty in recruitment."

Third, "action is needed to help Connecticut's dedicated primary care professionals to better meet the needs of their patients."[2]

OHS has not provided evidence for the Roadmap's proposals. 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 focus on practice supports, care management, evidence-based medicine, and data. This may naturally lead to more spending on primary care, but it would be spending in the right places.

Primary care physicians are very well compensated compared to critical healthcare provider and other occupations in Connecticut.

From the patient/consumer perspective, it is not clear that access to primary care is the most critical shortage facing Connecticut.

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

[1] Calculation from CMS National Health Expenditures, CT total healthcare spending, trends and projections with OHS estimate, Primary Care Subgroup 11/16/2021 meeting, that in 2019 primary care was 5.3% of total spending – compares 2025 vs. 2019 primary care spending

[2] Roadmap pp. 1-2.

US average. Five out of six Connecticut adults report that they have a personal relationship with a doctor/healthcare provider, ranking Connecticut tenth best in among states. While there is undoubtedly room for improvement, from the patient perspective, there is little evidence of an urgent need to double resources in primary care, causing sacrifice in other areas and risking patient care.

Advocates and experts have highlighted mental health, substance abuse, several types of specialty care, and emergency/urgent care as critical needs in Connecticut.

Who developed the Roadmap?
OHS only spoke to primary care provider organizations to determine the need for more resources. OHS and their consultants did not consult with or include specialists or independent consumer advocates in their planning.

The Roadmap builds on OHS's failed forerunner, under the State Innovation Model (SIM) project, that prompted concerns from advocates and providers, here and here, and from legislators.

The committee OHS convened to develop the Roadmap is dominated by primary care physicians and their needs. Twenty-one of the twenty-five committee members represent providers and insurers.[3]

Have other programs tried this?
Yes, and it has failed.

The Roadmap seeks to drive all Connecticut primary care into a capitated payment model. Under capitation, providers are paid a set fee each month for all the care their patients need. The set fee is adjusted based on medical needs, but not on social risks. Successful health systems

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. Since rejecting capitated managed care in 2012, Connecticut's Medicaid program has saved billions in tax dollars, expanded access to care, improved quality, and attracted providers back to the program.

How does the Roadmap plan fit with OHS's Cost Cap?
This is a critical point. OHS's increase in primary care spending, that **will cost $3.9 billion in 2025**[4], must come at the expense of other critical care. OHS plans to simultaneously double

[3] Roadmap, Appendix C.
[4] Calculation from CMS National Health Expenditures, CT total healthcare spending, trends and projections with OHS estimate, Primary Care Subgroup 11/16/2021 meeting, that in 2019 primary care was 5.3% of total spending – compares 2025 vs. 2019 primary care spending

primary care funds while cutting back resources for total healthcare spending. This will cause shortages of already scarce resources for other critical care.

What could go wrong?
There are serious concerns that, if implemented, the Roadmap could:

- Reduce, rather than expand, access to primary care
- Reduce resources for already scarce and costly critical care
- Raise overall healthcare costs
- Worsen health disparities in Connecticut
- Erode the quality of primary care
- People who need non-medical community, social services or behavioral health care could lose access and choice

Are some populations at greater risk?
Care for Connecticut seniors, people with disabilities, residents with chronic conditions, Medicaid members, and underserved low-income and communities of color are at greatest risk under the Roadmap. Individuals, families, and employers currently just barely able to afford health insurance are at risk if costs and premiums rise.

How will OHS monitor for harm to patients or rising health costs? What will they do about it if they detect harms?
OHS's plan to monitor for harm under the Roadmap and primary care capitation is dangerously weak. OHS plans to track less than half the measures DSS tracks in their controversial PCMH Plus shared savings plan and use mainly process measures rather than health outcomes. Broad outcome measures included in other programs, such as avoidable emergency room visits and hospital admissions, are not included. Under this plan, OHS would be very unlikely to identify any harms when they happen. It is important to remember that the lack of evidence, is not evidence that there is no underservice.

Potential harms to patients from OHS's weak underservice monitoring include serious mental health problems, missing substance abuse and poor outcomes, reductions quality of life due to loss of home health and other supportive care, loss of medication management causing dangerous interactions and other safety concerns, and poor birth outcomes.

What is the Roadmap's plan for funding?
OHS has been very consistent in advocating for primary care capitation over the years. Despite acknowledging the potential harm, the Roadmap continues to push that model.[5]

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. Since rejecting capitated managed care in 2012, Connecticut's HUSKY program

[5] Roadmap. P. 13.

which covers about one in four state residents, has saved billions in tax dollars, expanded access to care, improved quality, and providers have come back to the program.

In addition to its failures in savings and quality improvement, primary care capitation creates serious risks for patients and payers including underservice and stinting on critical care, incentives to refer patients out to more costly specialists, and incentives to expand primary care patient panels to unsafe levels.

Responding to primary care physicians' revenue concerns about sufficient revenues under capitation, the current version of the Roadmap makes primary care capitation a voluntary option for providers[6], but not so for patients. There is no provision for consumers to opt-out of the risky model.

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.

What aren't we funding if the Roadmap is implemented?
Increasing primary care spending in Connecticut to 10% of total healthcare spending will cost our state's healthcare system **$3.9 billion** more annually by 2025.[7] As OHS also intends to ratchet down total healthcare costs, Medicaid, Medicare, insurers, and the state would have to adjust their budgets to find billions in savings. Cuts could fall on payment rates or authorizations for mental health care, substance abuse treatment, oral health, specialty care, hospitals, clinics, community social services, the healthcare workforce, or any other area. OHS has not specified where the savings will come from.

What is the Roadmap's plan for quality?
In addition to very weak monitoring for harm, the Roadmap includes a dangerous erosion of primary care quality standards. The leader in primary care practice standards is Patient-Centered Medical Homes (PCMH). National, independent PCMH certification is associated with improved access to care, better quality, higher patient and provider satisfaction levels, and lower total healthcare costs.

In response to some primary care physicians' complaints about the burden of PCMH standards, the Roadmap creates a weaker OHS-designed PCMH certification system for practices that cannot or choose not to reach independent, nationally recognized standards that have been used in other states for over a decade. Those national standards are the bedrock of HUSKY's successful recovery from capitated managed care, saving the state billions of state dollars,

[6] Roadmap, p. 10.
[7] Calculation from CMS National Health Expenditures, CT total healthcare spending, trends and projections with OHS estimate, Primary Care Subgroup 11/16/2021 meeting, that in 2019 primary care was 5.3% of total spending – compares 2025 vs. 2019 primary care spending

expanded access to care, improved quality, and attracted thousands of providers back to the program.

As Connecticut learned when HUSKY was run through managed care organizations, data access and quality suffer under capitation. As providers are paid whether patients receive care or not, capitated models provide less transparency and accountability.

How will the Roadmap impact health equity?
As communities of color, women, seniors, people with disabilities, and other underserved populations are the most likely to lack necessary care, OHS's lack of monitoring and evaluation will hide harms to these communities and widen Connecticut's already large health disparities. OHS's plan to lower total health care spending simultaneously with primary care spending increases, will only heighten the risks to health equity.

Because the Roadmap's payment model does not include risk adjustment for social needs, patients who do not speak English, are without housing or transportation, are food insecure, face the stressors of living in poverty, or live in unsafe environments would not receive the resources needed to improve their health. These social risks fall hardest on Black and brown communities.

Are there better options to support primary care in Connecticut?
Yes. In 2019, to address SIM's risky primary care capitation proposal under OHS, the CT Health Policy Project published a report with 49 better, safer options to improve primary care in our state. The options, large and small, came from a literature search, interviews with Connecticut primary care providers, health system administrators, payers, state officials, and experts at the national level and from other states.

Didn't COVID make capitation for primary care necessary?
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. The next public health crisis may overwhelm capitated primary care practices, rather than reducing office visits. In that event, we should expect to hear primary care providers to call 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 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.