January 14, 2022

Victoria Veltri, JD, LLM
Executive Director
Office of Health Strategy
Health Systems Planning Unit
450 Capitol Avenue
MS#510HS P.O. Box 340308
Hartford, CT 06134-0308
victoria.veltri@ct.gov

RE: Testimony to OHS about the Roadmap

Dear Ms. Veltri:

My name is Arvind Shaw, and I am the Chief Executive Officer of Generations Family Health Center. On behalf of the rural patients in the northeast of Connecticut I am writing of my concerns about the roadmap for strengthening and sustaining Primary Care.

Having served on several boards (see listed below), I am sharing my perspective and appreciation of the enormous effort that is required to bring meaningful change to the healthcare delivery system. I have also served as an FQHC Chief Financial Officer for 13 years and have studied economics for 11 years.

- Northeast District Department of Health – Board of Directors, 2010 - 2018
- Commissioner – Asian Pacific American Affairs Commission, 2010 - 2015
- Commissioner – State of Connecticut Health Equity Commission, 2010 - 2014
- Member – SustiNet: Health Disparities & Equity Committee, 2010
- Member – Health First Connecticut Authority, 2008

Mis-managed Care

There are a several cautionary tales that bears repeating here from the mid-1990s when hundreds of medical, dental, and behavioral health Medicaid providers left the state or retired, unsupported through the system changes, and not willing to be decapitated by the managed care rollout of the Medicaid Waiver in Connecticut. In the process of implementation, MCO network adequacy was not evaluated and thousands of patients were in networks with no providers. This was especially true for behavioral health and dental services. Only after years of protests, the State's Attorney

General sanctioned and shutdown some of these state approved plans and, ultimately, the state itself was sued for not providing dental services to Husky children through the Managed Care Program. In eastern Connecticut the safety net never recovered from this, and after twenty years, *Windham County is still ranked last in the state in most health outcomes*.

Supply-side

The major assumption these models make is that there is the same elasticity of supply throughout the state. When in fact, in the rural part of the northeast, not only is the supply chain without the same density of workforce, the access to behavioral health services is clogged with waiting lists that are months long for decades. Psycho-social factors are the greatest cost contributors to medical cost, and not addressing this upfront is baking into the region spiraling healthcare inflation and the accompanying health disparities and inequities that has been well documented in the state.

Another supply-side assumption is that throughout the state patients have the same access to transportation, which is exacerbated by the non-service of patients, as outlined in the State performance audit report of DSS's and Veyo's NEMT which shows the waste of public resources, and uncompensated cost shifts to service providers:

- 4,954 provider no-shows
- 317,061 late pick-ups
- 925 substantiated complaints for provider no-shows
- 461 substantiated complaints for late pick-ups

Our experience at Generations has been that disabled patients who are wheelchair and stretcher bound have a history of having their care disrupted because of the lack of inventory (vehicles that can safely transport them) available for disabled patients. *Today this is a very urgent problem.*

Another supply-side assumption is that access to hospital services is uniform throughout the state, which is just not true. Windham Hospital has greatly reduced access to hospital-based services forcing patients to receive care elsewhere through a medical transportation system that is broken.

These are cost accelerators and reduce both access and quality. The increased costs and consolidation of services in the region will also make it harder for providers to participate in any meaningful value-based contracting at a time when the increasing costs of services for rural patients have increased at twice the rate of other populations as evidenced in the PCMH+ data. Without the active management of the supply-side of healthcare delivery, it is unwise to assume that the "invisible hand" of the marketplace will provide the access and quality that is espoused.

Inside the PCMH+ experience

The PCMH+ program that was originally proposed to the state and presented to the legislature was never implemented in the way it was presented by the Department. The numerous objections that were raised during the hearings and the public comment period were cured by the Department's rosy assertion that reference groups that were to be used would be uniquely tailored to each practice and so the strategy for providers was to use the reference groups to inform their strategy. Generations was to be provided processes and the data to uniquely inform

our strategy. However, what was implemented statewide was a "one-size-fits-all" and that set up the inflexibility and inability to correct the PCMH+ program.

- In the first year due to a misreading of the Medicaid redetermination process, the program lost one third of its membership. The Department took months to figure out why the work plan was not conforming to the model that had been "sold" to the participants. Due to "churn" in member enrollment, the program was out of balance immediately, with enrollment plummeting every month. **Thirty-four percent of the potential savings were withheld from the system due to this costly error in the first year itself for Generations.**

- The PCMH+ asserted that there is no downside risk, while in reality the lack of understanding forced the acceptance of these environmental underservices as "it affected all patients" not just Generations' patients. Such is the nature of the bureaucratic determinants of health.

- Similarly, the PCMH+ management claims that "that was your (Generations) own decision about allocation methodology and staffing patterns, not ours" to avoid responsibility of the mismanagement of Veyo services in the state, as the data that they had showed "it affected all patients".

- In the very first year the savings that Generations generated (22%) were never returned to Generations community because even though the quality was better, as the cost increases exceeded the state average.

- The practices that were awarded greater shared savings had greater costs and lesser quality.

- The data that we requested was never provided. To remedy, we met every year with DSS with requests these same promises while all the savings passed us by.

- The Department maintains that "the other aspects that you discussed (e.g. Veyo, hospital reimbursement) impact all of the PCMH+ PEs equally. If you disagree, please show us your data so that we can take it into consideration." The state audit has now provided the Department the data and still there was no process to address our concerns about the cost shift to PCMH+ providers. The PCMH+ has the cost increases but has no way to address the shortcomings.

- If the PCMH+ had foreseen this they would have planned the risk adjustment and that may have preserved the integrity of the program, and we would not have to wait for the legislature or courts to adjudicate the matter.

Feedback and course correction measures:

These are real time examples that have caused the state to miss major savings opportunities because of the lack of corrective mechanisms and management. There is also a need for the state to maintain population health standards for all communities so that minority equity is preserved in the form of access and quality in the communities from which demand originates.

Payment reforms have been beneficial and can be sustainable and avoid being inflationary if it is accompanied with demand and supply measures that safeguard minority health equity and that are population health-based. What is lacking in the Roadmap's approach is the evaluation and regulatory mechanism for measuring SDOHS- access, quality, and equity to correct course after a system launch.

There is also a need for an objective review committee with sanctioning authority to see that patient rights are preserved for all patients including the uninsured and the underinsured so that safety net providers are not solely burdened with providing care to the uninsured and underinsured without adequate resources.

The additional funding and voluntary nature of these changes, I suspect were the easiest to agree upon however the mechanism for management in a changing environment is a necessity for the sustainability of these innovations, and therein lies the rub.

I hope and trust that all of these items are within your purview and these suggestions to improve are useful to consider as you proceed.

With best wishes for a happy and healthy new year.

Sincerely,

Arvind Shaw
Chief Executive Officer