CONNECTICUT HOSPITAL ASSOCIATION

January 14, 2022

Victoria Veltri
Executive Director
Connecticut Office of Health Strategy
P.O. Box 340308
450 Capitol Avenue, MS#51OHS
Hartford, CT 06134

Dear Ms. Veltri,

On behalf of the Connecticut Hospital Association (CHA) please accept the below comments on *The Roadmap for Strengthening and Sustaining Primary Care* ("Roadmap"), which sets forth the Office of Health Strategy's (OHS) proposed strategy to improve and reform primary care, with actionable steps for more effective, efficient, and equitable primary care to better meet the needs of patients and sustain primary care professionals. We strongly support the Roadmap's focus on strengthening primary care, which we believe is an essential foundation for a high performing health system.

It is widely recognized that primary care is an essential means to achieving better preventive and chronic care outcomes for patients of all ages. More effective team-based care can provide patients with ongoing support between visits, identifying and resolving issues before they result in avoidable visits to the emergency department or hospital admission. The use of health coaches can support lifestyle changes that are effective for chronic condition management, navigators can help patients negotiate a sometimes complex array of healthcare services and supports, and community health workers can identify social, economic, and environmental issues that threaten to defeat patients' best efforts to manage their recovery. And in the face of worsening opioid abuse and pandemic associated stress, primary care can be a means to support appropriate methods for pain management and provide enhanced access to timely, integrated behavioral healthcare.

Primary care could be further enhanced by considering the range of new patient care needs that have resulted from the pandemic. For example, individuals have been seeking routine COVID-19 testing, which has created an acute strain on our hospital emergency departments, when these needs could easily be addressed in primary care settings. This example illustrates that primary care could perhaps be better equipped to respond to acute changes in their community's public health and healthcare needs.

All of the above will help address the profound disparities in health and healthcare outcomes that affect so many persons in Connecticut, whether related to income, race and ethnicity, disability status, gender identity, or sexual orientation. Now more than ever, health equity must be a shared priority and focus of action for state policy makers, payers, and service delivery providers.

Core Functions

We also support the identified core functions, which cover a range of generally accepted capabilities associated with advanced primary care. We appreciate the level of specificity used to describe the core functions, which avoid the pitfall of prescribing clinical practices and care team composition, thus affording providers the opportunity to demonstrate through innovation a pathway to high value care.

We strongly endorse the *inclusion* of behavioral health integration, specifically that behavioral health is "integrated into the practice team through a) mental health clinicians who are members of the practice and provide assessment, brief treatment and referral, and b) screening and referral for substance misuse treatment." **However, we believe that integration should only be among the core functions if expenditures for such integrated services are counted as a primary care expenditure in testing performance against the benchmark.** In the absence of such, this requirement represents an unfunded mandate on providers as they will be required to provide these services whether or not payers agree to reimburse for them. Paying for such services will not enable payers to achieve the primary care benchmark and thus such expenses cannot be justified to their self-funded clients as a required expense for the purpose of achieving the benchmark. Moreover, payers will have no incentive to do so, as their members would essentially be accessing these services free of charge.

Payer Commitment of Resources

Despite the strengths of the Roadmap and the 11 core functions, we have serious concerns about payers' willingness to commit resources sufficient to enable primary care providers to build these advanced primary care capabilities and offer them to all of the patients they serve. Today, primary care practices provide direct services and supports to all patients, regardless of payer. It is neither realistic nor reasonable to demand cost-efficient patient care, yet require that practices engineer care protocols and team composition based on a patient's payer or benefit package. Conversely, it isn't realistic to expect that practices will build enhanced care teams and capabilities for all patients, when some payers may be unwilling or unable to subsidize these capabilities. In this latter scenario, providers end up bearing the cost of care delivery enhancements that only a subset of payers support.

We are concerned that commercial payers' participation will be contingent on the willingness of their self-funded employer clients to go along with the plan. There is no evidence that OHS or commercial payers have engaged these employers to solicit their buy-in. Given that self-funded employers comprise more than 70% of the commercial market, this seems a fundamental threat to the viability of the Roadmap.

We are even more concerned about Medicare fee-for-service (FFS), which provides coverage for the state's patients with the greatest healthcare needs, patients who will be among the most reliant on these new primary care capabilities. Unlike OHS's previous Primary Care Modernization initiative where Medicare FFS and other payers would have committed to providing financial support for primary care enhancements prior to the launch of the initiative, there is no such commitment offered here.

In the case of the Medicare FFS population alone, **we estimate that the *additional cost* of increasing primary care spend for Medicare FFS beneficiaries from its current level of approximately 3.1% to 10% will exceed *a quarter of a billion dollars per year***. Providers that attest to achieving these capabilities for their patients will either have to bear this unfunded mandate on their own, or shift still more of the healthcare dollar to commercial payers.

Finally, we believe that Medicaid has a greater contribution to make than the baseline estimate of 9.4% would suggest, and that an adjusted Medicaid contribution will be essential to the success of the program. Although we recognize that the Medicaid's primary care reimbursement exceeds that of Medicare for PCMH-recognized practices, the current primary care percentage is overestimated because Medicaid's rates for services that comprise the denominator, specifically, hospital and physician subspecialty services, are far below those of Medicare and far below the cost of providing them. Hospital inpatient, outpatient, and physician reimbursement is on the order of 55 to 65% of Medicare. If this calculation was normalized by pricing services that comprise the denominator at Medicare levels, the percentage would be less than 7%.

We believe that OHS should delay implementation of this program until such time that it has the commitment of the majority of payers, especially Medicare and commercial self-funded, to generate levels of reimbursement sufficient to achieve the standard of care to which the Roadmap aspires.

We thank OHS for its leadership in this important care delivery reform and greatly appreciate the opportunity to comment. We believe that success is imperative and can be met only with the universal commitment of all-payers to these goals and capabilities.

We look forward to remaining engaged in the process to strengthen investments in primary care. We appreciate the opportunity to comment on the Roadmap, and look forward to additional opportunities to offer guidance.

Thank you for your consideration.

Sincerely,

Paul Kidwell

Paul Kidwell
Senior Vice President, Policy

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