

To: Vicki Veltri, Office of Healthcare Strategy
Mark Schaefer, Office of Health Care Innovation

From: People with Disabilities and Advocates for People with Disabilities

Date: November 16, 2018

Re: Opposition to Proposal to Capitate Primary Care Providers (SIM “Modernization” Plan)

A number of us have been contacted by your consultants, Freedman Healthcare, to seek our support for the plan to pay primary care providers a fixed payment per member per month (“pmpm”). We are writing today to express our continued opposition to this capitation proposal and to the efforts to enlist people with disabilities, including those on the Long-Term Care Rebalancing Committee and the CT Cross Disability Lifespan Alliance, to support it. Our opposition is based on our experience of your office’s failure to listen to the voices of dozens of consumer advocates, including advocates for people with disabilities, who have related their concerns that this payment model could be harmful to patients, particularly those with complex medical conditions.

This latest outreach effort followed a meeting of the SIM Steering Committee on September 13, 2018, at which several members complained about the August 23, 2018 written comments of 31 independent advocates (including some of us) in opposition to the capitation plan (comments attached). See <http://www.ctn.state.ct.us/ctnplayer.asp?odID=15603> (starting at 1:42:45). It was stated there that the SIM group had somehow failed to properly “educate” the community about what the plan was, and that there was “confusion” about the plan, rather than any acknowledgement of, or having a substantive discussion about, these advocates’ valid concerns. The group concluded that there was a need to go back to the community with the goal of getting them on board to support the plan which had already been largely developed (and completely developed, in the case of the core capitated payment model).

We in the disability community are not confused about the plan. We understand what the payment mechanism is, and what it is designed to accomplish. That is why we are so concerned and continue to object to it. A plan that capitates payment to primary care providers is likely to result in less care for a population (people with disabilities) that needs it most: restricted access to essential care, failure to inform patients about more expensive care options, and denials of critical tests, because every dollar of health care provided by the primary care provider comes out of their pocket. We know exactly what the model is and we oppose it.

In previous presentations to disability groups, a series of claims has been made in the attempt to enlist support for this payment model, as discussed below.

Your consultants refer to the proposed change in payment as “modernization” when capitation has, in fact, been tried before in the Medicaid program. It failed, which is why it was replaced in January 2012 with a managed fee for service program (now run by DSS and contracted “administrative services

organizations” paid on a non-risk basis), which is not only more efficient but has also both saved the state hundreds of millions of tax dollars **and** improved access to care. The number of participating primary care providers has significantly increased. This latest proposal represents a change in that it would capitate payments to providers rather than insurers- but this is precisely the reason why we are concerned about its impact on patients with disabilities and other chronic conditions who need complex care. The proposal may result in placing providers, who will be principals in or employed by the capitated entity, in a direct financial conflict with their patients’ best interests. Capitation of primary care providers specifically was already tested by commercial HMOs in the 1980s, and failed. It does not make sense for Connecticut to move forward with a plan design that has already been tried, with poor results, in the past.

We support the concept of “flexibility” for primary care providers to hire community health workers, provide telemedicine and other innovations. However, we do not believe that the payment mechanism that is an essential part of this plan design would accomplish that goal. Under capitation, there is no assurance that **any** of these services, all of which must be paid out of the provider’s pocket, would actually be provided. There seems to be a failure to acknowledge that most of these services could be covered via Medicaid fee for service under a simple state plan amendment. Providers already have the “flexibility” to pay for non-covered services out of their own pockets, if they choose to do so. However, a per member per month payment system would create disincentives even for the provision of standard office visits, since providers would receive little or no payment for these. People with disabilities do not have this worry under the current Medicaid fee for service model.

In fact, at SIM Payment Reform Council meetings it has been offered to providers that, by **reducing** visits, they will generate more revenue by taking on more patients (with each patient bringing in a pmpm payment regardless of any services provided) without needing to expand capacity. The Medicaid system should be operating for the benefit of the patients receiving care, not the profit margins or administrative convenience of the providers of medical care.

Promises have also been made about a “doubling” of funds for primary care, with no explanation of where that money would come from. People with disabilities have had promises made to them in the past; rarely have those promises actually been kept. Even if more funds were somehow to be made available for primary care, this does not eliminate the incentive, under a capitated payment model, for a provider to limit access to care, because the cost of that care still would come out of the primary care provider’s pocket.

Risk adjustment through making higher pmpm payments for people with complex conditions will not necessarily stop providers from discriminating against people with disabilities with greater health care needs. In fact, it may provide a perverse incentive for a provider who receives the higher differential payment for accepting people with disabilities as patients to **then** deny them care, because that would result in additional profit to the provider. Unlike a fee for service model, a capitated payment model does not condition payment on the provision of services. The provider gets the same amount of money regardless of the services provided. The plan includes no meaningful or realistic

proposals to monitor either for the dumping of expensive patients or for underservice. People with disabilities and other chronic conditions requiring complex care are particularly threatened under this payment scheme, with or without risk-adjusting.

We are particularly troubled by the fact that previous written comments from large groups of independent advocates (dated April 9, 2018 and August 23, 2018) urging you to reconsider this payment model seem to have been ignored, and no changes to the payment model have occurred in response to these comments. It appears to us that you are not looking for any meaningful input, but instead only seeking to obtain post-hoc endorsements of your proposal. Because we continue to have serious concerns about the threat to the health of people with disabilities, we cannot support this plan.

Finally, we wish to note that we are not ignoring some access issues under the current Medicaid system. For example, people seeking mental health services report being steered toward group therapy instead of individual therapy and being given very short appointments, presumably to save the state money. Similarly, we are aware that significant health disparities remain, with people of color often given less treatment or less expensive treatment than white patients due to implicit bias – even when the provider does not have a financial stake in reducing the cost of care. While we would like to address these deficiencies and have some ideas for doing so, capitating primary care providers will only make these problems **worse** by affirmatively incentivizing providers to deny appropriate services.

We do not need to be “educated” about what this plan proposes. We understand what the SIM proposal would do, and we are concerned about the potential for adverse consequences which seem to have been completely discounted by those advocating for it. However, if SIM is willing to restart the process and genuinely hear suggestions with no pre-determined payment model in mind, we remain happy to work with you toward **real** primary care reform that supports both people with disabilities and providers.

Thank you for your attention to these comments.

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