October 18, 2021

Vicki Veltri
Executive Director
Office of Health Strategy
450 Capital Avenue
Hartford, CT 06016

RE: Primary Care Payment Model Proposals

Dear. Ms. Veltri:

On behalf of the Connecticut Association of Health Plans (CTAHP), I would like to express the industry's sincere appreciation for the work done by the Office of Health Strategy (OHS) in furtherance of Governor Lamont's Executive Order #5 to develop cost growth benchmarks and to refocus resources to primary care in order to decrease escalating health care costs. We welcome the continued conversation and believe it is integral to strengthening Connecticut's health care infrastructure. It is in that vein that we offer the following comments and questions with respect to the Primary Care Payment Models currently under consideration by the Primary Care "Subgroup".

As Connecticut moves down this path, it is critical that financial incentives be tied directly to intended outcomes. We must take into account the impacts experience and lessons learned by other states and incorporate them within the context of Connecticut's unique environment. While increased investment in primary care is a worthy pursuit and expected to result in a reduction of overall medical spend, unless there is accountability for performance and clear off-sets to increased spending, such initiatives could have the opposite impact. CTAHP seeks to work together with OHS to assure that there are strong mechanisms in place to ensure that corresponding reductions in hospital and specialty care accompany any increase in primary care reimbursement.

Through the good work of OHS in developing a self-sufficiency tool to measure the affordability of health care, the agency is already well aware of what unanticipated increases could mean to the availability of stable and accessible insurance coverage. As such, consideration should be given to incorporating various if "X" then "Y" scenarios into any implementation plan. Doing such will avoid any unforeseen (or potentially foreseen) consequences.

With these issues in mind, CTAHP respectfully opposes any mandates requiring primary care increases without a corresponding mandate automatically lowering the cost of specialty care - one that is supported by consumers, providers, and employers alike. This is particularly important given that over 65% of Connecticut's market is self-insured and therefore outside the reach of state regulatory purview. In order to drive meaningful change that will impact all Connecticut residents, both regulated and non-regulated, an approach that is voluntary, flexible, and consensus driven is paramount. Additionally, please note that benefit plan design (i.e. gated vs PCP selection with open access vs no PCP requirement) plays a large role defining consumer behavior.

Employers need to be aligned in this journey and be willing to help drive a shift towards choosing more PCP-centric plans.

With alignment and consensus will come success. In attaining such agreement, it will be important that OHS be able to answer the following questions:

1. How do Accountable Care Organizations fit within the Primary Care Model discussion?
2. How often will risk models and investments be evaluated and on what basis? What will be the recourse if such models are found to not attain the desired outcomes?
    a. Will a statewide cost analysis be undertaken? What is the baseline to determine success?
3. How will we measure the cost of specialty care to assure it is decreasing accordingly with an increase in primary care spend?
4. How will the approach differ for hospital-owned PCP organizations that have more resources than an average non-system owned PCP practice?
5. How does the data support enhancing PCP payment and is there a study that demonstrates the amount needed that will promote greater health and reduce overall costs? How many providers are ready for capitation vs. fee for service today? How will readiness be addressed?
6. Where does product selection/benefit plan design come into play?
7. What are the protocols for the attribution model? Will innovation and flexibility in the creation of these models between plans and providers remain?
8. Is there a shortage of primary care providers? If so, what strategies will be employed to increase the overall number of PCPs or further the use of advanced practice providers to support these models?

It is imperative that the above questions be answered to allow for additional consideration and discussion amongst the Subgroup before any final guidance is released. This step should be a priority as it will help to provide the foundation necessary for continued development.

Thank you again for the opportunity to comment.

Sincerely,

Susan Halpin

Susan J. Halpin
Executive Director
Connecticut Association of Health Plans