Cost Growth Benchmark Technical Team Meeting #6
July 2, 2020

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Agenda

Time	Topic
1:00 p.m.	I. Call to Order
1:05 p.m.	II. Review and Approval of Prior Meeting Minutes
1:10 p.m.	III. Public Comment
1:20 p.m.	IV. Stakeholder Advisory Board Feedback
1:40 p.m.	V. Primary Care Spending Target Methodology
2:55 p.m.	VI. Wrap-Up and Next Steps
3:00 p.m.	Adjourn

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Approval of June 16, 2020 Meeting Minutes

Public Comment

Stakeholder Advisory Board Feedback

General Feedback on the Benchmark Implementation

- There was general concern voiced by some about a cost growth benchmark creating incentives for providers to limit services.
  - Members were receptive to benchmark implementation being accompanied by a strategy to monitor for potential unintended consequences, particularly for vulnerable populations.
- A member highlighted the importance of tracking data on spending on the uninsured, and suggested that opportunity exists to ask the provider community about data they collect on payments received from the uninsured.
- A member emphasized that although a cost growth benchmark does not attempt to address plan benefit design, the complementary data use strategy should still track trends in this area, and efforts to address health care cost growth are incomplete without this information.
- A member suggested calculating health care spending trend, without setting any benchmark.

Feedback on the Benchmark Methodology

- A SAB member suggested making the third criteria for selecting a benchmark methodology more explicit, to state "lower growth in spending *for households, employers and taxpayers*."
- There was a suggestion to use a 90/10 weighting of potential gross state product and median income, due to a concern that the current methodology yields a value that is too low, and will lead to access and quality issues.
- One member echoed the Technical Team's concerns over income inequality, and suggested using the 25th percentile for wages rather than median wage.
- Some felt that using only a significant increase in inflation as a trigger for re-visiting the benchmark value is too narrow, and that additional triggers should be identified.

Discussion of Stakeholder Advisory Board Feedback

- Based on the feedback you just heard, does the Technical Team wish to maintain or revisit its recommendation to OHS to use a **20/80 weighting of potential gross state product and median income** as the benchmark, and set values that decline over five years and average **2.9%** follows:
  - 2021: 3.1%
  - 2022: 3.0%
  - 2023: 2.9%
  - 2024: 2.8%
  - 2025: 2.7%

Raise Hand

Primary Care Spending Target Overview

Directive to develop a primary care spending target

- Executive Order #5 directs the Executive Director OHS to:
  - "…monitor health care spending growth across all public and private payers and populations in Connecticut…",
  - "..convene a Connecticut Cost Benchmark Technical Advisory Board to assist her in developing such benchmarks…" and
  - ensure "**such health care cost growth benchmarks shall account for current primary care spending and set targets within each annual benchmark for increased primary care spending as a percentage of total health care expenditures to reach a target of *10% by calendar year 2025*.**"

Why Set a Primary Care Spending Target?

Why set a primary care spending target?

- The U.S. healthcare system is largely specialist-oriented. Research has demonstrated that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience of care.
- States have elected to utilize primary care to strengthen their healthcare systems by:
  - ***supporting improved primary care delivery*** (e.g., expanding the primary care team, supporting advanced primary care model adoption)
  - ***increasing the percentage of total spending that is allocated towards primary care***.

State example: Rhode Island

- Background: Primary care spending target established through commercial health insurance regulation.
  - Rhode Island Office of the Health Insurance Commissioner (OHIC) implemented "affordability standards" in 2009, with the guidance of its Health Insurance Advisory Council.
  - One of the initial four standards required commercial insurers to ***increase the portion of medical expense allocated to primary care by one percentage point every year for five years*** without increasing premiums or fee schedule manipulation.
    - Re: "fee schedule manipulation", RI wanted innovative contracting and payment, as well as primary care system investment, and not simply changing rates of reimbursement for specific codes.

State example: Rhode Island – Results

- From 2008 to 2018:
  - Commercial primary care spending as a percentage of total medical spending increased from **5.7%** to **12.3%**.
    - Total fully insured primary care spending increased 66% from $47 million to $78 million.
    - Total fully insured medical spending decreased 22% from $823 million to $638 million.*

*RI believes the decline was due to growing use of self-insurance, leakage to Medicaid from ACA expansion, and an aging population.

State example: Oregon

- Background: Primary care spend reporting and target required by statute.
  - Senate Bill 231 (2015) and House Bill 4017 (2016) required the Oregon Health Authority and Department of Consumer and Business Services to ***report the percentage of medical spending allocated to primary care*** for select health insurers in the state.
  - Senate Bill 934 (2017) required health insurance carriers and Medicaid coordinated care organization (CCOs) to allocate at least ***12 percent of health care expenditures to primary care by 2023***.

Building upon work in Connecticut

- The Technical Team's work on a primary care target will benefit from prior and concurrent work in the state.
  - Connecticut is participating in a collaborative with the other New England states to measure primary care spending using a consistent methodology. This work is sponsored by the New England States Consortium Systems Organization ("NESCSO").
  - Other Connecticut work related to primary care that may inform this effort:
    - Freedman Healthcare's analysis of Connecticut primary care spending
    - Practice Transformation Task Force

How much does Connecticut spend on primary care?

How much does CT spend on primary care?

- It is important to know the level of Connecticut's recent spending on primary care. Otherwise, it will be hard to chart a course to reach the Executive Order #5 directive to increase primary care spending as a percentage of total healthcare spending to 10% by 2025.
- Answering this question is not a simple task.

It's unclear what Connecticut spends on primary care!

- Three separate analyses have been performed recently to calculate what percentage of total healthcare spending has gone to primary care.
  - The measured populations, time periods and methodologies have varied across the three efforts.
  - As a result, it is not surprising that their results have varied too.
- A *fourth* analysis is currently underway, this one being performed as part of the NESCSO project. Preliminary results should be available by the end of the month, and final results by the end of August.

Calculations of CT Primary Care Spend %

Source	Data Source	Payer Markets	Years
Freedman Healthcare*	OSC claims DSS claims	Commercial (state employees) Medicaid	2017 (Commercial) 2018 (Medicaid)
Patient-Centered Primary Care Collaborative (PCPCC)	MEPS (survey)	Commercial Medicaid Medicare Dually Eligible	2011-2016
UConn SIM evaluation	APCD claims	Commercial Medicare	FFY2013-2017 (Commercial) FFY2013-2017 (Medicare)**

*Freedman also reported the MEPS figure for Medicare.
**Medicare pharmacy data is from FFY2013 – FFY2015.

For more information about the definitions each source utilized to calculate primary care spending, see the appendix.

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What did these three efforts find?

- Primary care spending in Connecticut varies drastically based on the definition of primary care (the numerator), the definition of total medical expense (the denominator) and the data source!

Using claims as the primary data source

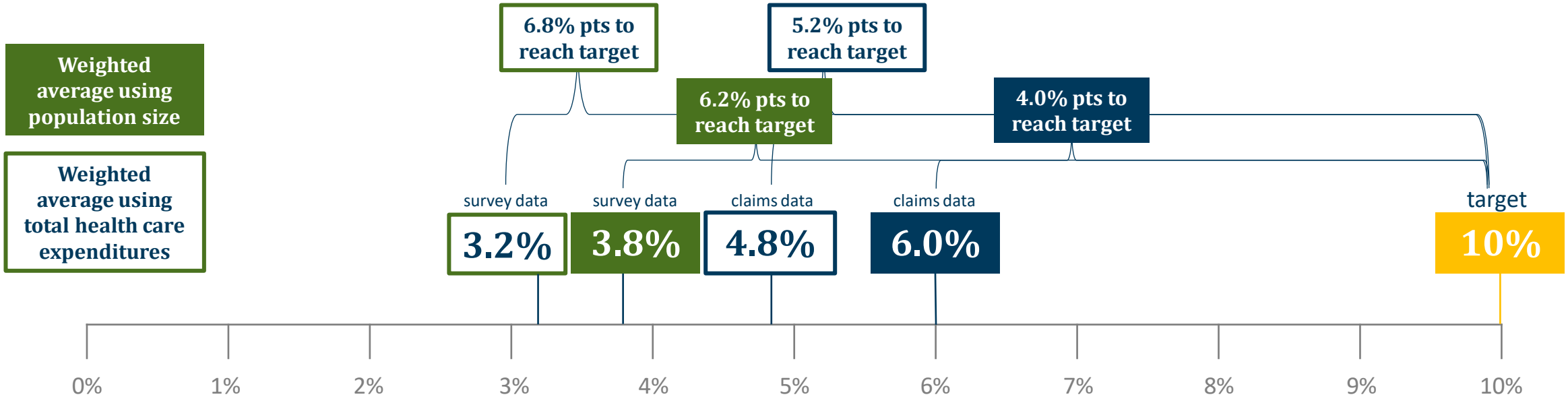
Payer Markets	Years	Primary Care Spending %	Source
Commercial	FFY 2017	5.8%	UConn SIM
Medicaid	2018	9.0%	Freedman
Medicare	FFY 2017	2.7%	UConn SIM

Using MEPS survey data as the primary data source (traditionally less reliable)

Payer Markets	Years	Primary Care Spending %	Source
Commercial	2011-2016	3.6%	PCPCC (Narrow)
Medicaid	2011-2016	5.4%	PCPCC (Narrow)
Medicare	2011-2016	2.1%	PCPCC (Narrow)
Dually Eligible	2011-2016	2.5%	PCPCC (Narrow)

Where does this leave us? (cont'd)

- If we calculate a weighted average of total primary care spending in Connecticut by (a) population size and (b) total health care expenditure, spending varies dramatically by data source. This has major implications for what action is needed to reach the 10% target.



Source: Bailit Health analysis using data from the Freedman Healthcare analysis, the UConn SIM evaluation report, the PCPCC primary care report, the Kaiser Family Foundation Health Insurance coverage estimates for 2018 and CT DSS Medicaid spending estimates.

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Implications for our work

- As seen in the previous slides, primary care spending varies across public and private sectors, regardless of the data source.
- These findings have three major implications:
  1. The Technical Team must develop a precise definition of primary care and total medical spending.
  2. The Technical Team should rely on calculating historical spending using this precise definition in order to set specific annual targets to reach the Executive Order's target of 10% by 2025.
  3. The Executive Order sets the target in aggregate across payers. It will be challenging to get to 10% given Medicare's inclusion in the calculation.

Roadmap for Primary Care Spending Target Work

Primary care spending target methodology

- As demonstrated by the prior slides, measuring primary care spending relies heavily on two key questions:
  1. **What is the definition of primary care?**
  2. **What constitutes primary care payments?**

Primary care spending target methodology (cont'd)

- We will now walk through key decisions that must be made to define primary care. We will draw from NESCSO's work and from the experiences of other states to provide options for you to consider.
  - NESCSO has multiple definitions of primary care. The "core" definition is narrower in scope and is utilized throughout the following slides. The broader definition, for example, classifies select obstetric/gynecological services as primary care.
  - Neither the Freedman nor UConn analyses documentation had enough consistent detail to inform the conversation on the next slides. Any detail available is shared on the appropriate slide.

Roadmap of key decision points

1. Selecting the Data Source(s)
2. Defining Primary Care
3. Defining Primary Care Payments
4. Defining Total Payments
5. Defining the Population
6. Defining the Payers
7. Collecting Information to Support Complementary Analysis
8. Setting the Target
9. Finalizing Data Collection, Analysis and Reporting
10. Identifying Unanticipated Consequences

Selecting the Data Source(s)

Which data sources should one use?

- In order to collect data on primary care and total spending, the Technical Team must consider which data source(s) it wishes to utilize:
  - the All-Payer Claims Database (APCD)
  - direct payer reporting
  - a combination of the two
- Data availability strongly influences how the Technical Team can operationally define primary care. For example, without the use of payer reporting, the definition of primary care spending will be focused on claims-based spending only.

What data sources do others utilize?

Data Source	CT Cost Growth Benchmark	Rhode Island	Oregon	NESCSO
APCD	No	No	Yes	Yes
Direct payer reporting	Yes	Yes (Excel template)	Yes (Excel template)	Yes (Excel template)

Advantages and disadvantages of different data sources

	Advantages of this Data Source	Disadvantages of this Data Source
APCD	• Already in use in the state • Has data to calculate claims-based spending • Includes information to stratify data (e.g., by zip code) • Easier to collect data at provider organization-level	• Does not include self-insured data • Includes almost no non-claims data (some capitation included) • Payment recorded may not represent final payment • Lag before data are available
Direct payer reporting	• Ability to customize template to align with Technical Team's recommendations • Can add primary care spending reporting to cost growth benchmark template (as is to be done in Delaware)	• Payer and state effort and expense associated with data collection and reporting • Need a validation process to ensure data accuracy

Advantages and disadvantages of different data sources

	Advantages of this Data Source	Disadvantages of this Data Source
APCD and supple-mental payer reporting	• Allows OHS to develop a more comprehensive definition of primary care than using either data source alone • Can capture both claims and non-claims spending, similar to the cost growth benchmark • Can align reporting templates and timeline with the cost growth benchmark (as is done in Delaware) • Allows OHS to use a common definition and methodology to collect data as other New England states (and CA)	• Does not include self-insured data • Payer and state effort and expense associated with data collection and reporting on non-claims data • Need a validation proves to ensure data accuracy for non-claims reporting

Connecticut's required data sources

- Based on what you just learned, what data source(s) does the Technical Team wish to recommend for calculating primary care spend – APCD, direct payer reporting, or both?

Raise Hand

Defining Primary Care

What is primary care?

- The definition of primary care can be sub-divided into the following two questions:

1. What services are considered “primary care services”?
2. Who are “primary care providers”?

1. Which services are considered "primary care services"?

- The following tables summarize categories of codes that are included in various definitions of primary care. There may be code-level differences within the categories that are not highlighted here.

Service Type	Rhode Island	Oregon	NESCSO
Office or home visits	No service restriction (except lab, x-ray and imaging)	Yes	Yes
General medical exams		Yes	Yes
Routine adult medical and child health exams		Yes	Yes
Preventive medicine evaluation or counseling		Yes	Yes
Telehealth visits		Yes	Yes
Admin. and interpretation of health risk assessments		Yes	Yes

1. Which services are considered primary care? (cont'd)

Service Type	Rhode Island	Oregon	NESCSO
Routine obstetric care excluding delivery	No service restriction (except lab, x-ray and imaging)	**Yes**	No
Behavioral health risk assessments, screening and counseling		**Yes**	**Yes**
Minor outpatient procedures		No	No
Immunizations (e.g., vaccines and vaccine administration)		Yes (vaccine and administration)	Yes (administration only)
Inpatient care		No	No
ED care (e.g., suture removal, splinting)		No	No
Nursing facility care		No	No
Hospice care		No	**Yes**
Practice-administered pharmacy		No	No

Definition of primary care services

- Based on what you just learned, what approach does the Technical Team wish to take to recommend a technical definition of primary care services?

2a. Who are primary care providers?

Provider Type	Rhode Island	Oregon	NESCSO
Primary care MD specialties	Yes – family practice, internal medicine, pediatrics, geriatrics	Yes – family medicine, general medicine, pediatrics, preventive medicine	Yes – family medicine, general practice, internal medicine, pediatrics
NPs and PAs	Yes	Yes	Yes
Geriatrics/gerontology	Yes	Yes	Yes
Behavioral health	Yes, but only if accepting the role and fees of a PCP	Yes – psychiatry and general psychiatry	No
OB/GYN and/or midwifery	See “behavioral health”	Yes – OB/GYN	No
Naturopathic health care providers	No	Yes	No

2b. Who are primary care providers?

Practice Type	Rhode Island	Oregon	NESCSO
Primary care clinics	No*	Yes	Yes
Federally qualified health centers (FQHCs) and rural health centers (RHCs)	No*	Yes	Yes
School-based health clinics	No*	No	Yes

*Rhode Island does not explicitly include or exclude these practice types. It provides a definition of a primary care practice as a practice of a physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care.

Definition of a primary care provider

- Based on what you just learned, how do you recommend primary care provider be defined?

Raise Hand

Defining Primary Care Payments

What constitutes primary care payments?

- The definition of primary care payments can be sub-divided into the following two questions:
  1. How does one define “service payments”?
  2. How does one define “non-service-based payments”?

1. How does one define service payments?

- **Rhode Island**: payments based on **paid medical claims**
  - Rationale: health plans have the ability to only control paid amounts
  - Note: Rhode Island modeled historical trends for allowed and paid claims and found that while allowed claims were higher than paid claims, there were no differences in overall trend.
- **Oregon**: payments based on **paid medical claims**
  - Rationale: legislators and advocates were focused on plan investments in primary care
- **NESCSO**: payments based on **allowed medical claims**
  - Rationale: New England states expressed a preference for allowed amounts

Note: Allowed amounts include the amount the payer paid to a provider for a health care service, plus any member cost sharing for a claim. Paid amounts include only the amount the payer paid to a provider.

Definition of service payments

- Do you recommend the definition include paid or allowed payments?

2. How does one define non-service-based payments?

Payment Type	Rhode Island	Oregon	NESCSO
Care management	Yes	Yes	Yes**
PCMH infrastructure	Yes	Yes	Yes**
Pay-for-performance	Yes	Yes	Yes**
Shared savings distributions	Yes	Yes	Yes**
Capitation	Yes	Yes (including provider salaries)*	Yes**
Episode-based payment	Yes	Yes	Yes**
EHR/HIT infrastructure	Yes	Yes	Yes**

*Closed health systems (e.g., Kaiser Permanente) contribute to provider salaries in addition to capitation in Oregon.
**NESCSO will be finalizing its definition of non-service-based payments in early July. The categorizations here reflects tentative decisions.

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2. How does one define non-service-based payments? (Cont'd)

Payment Type	Rhode Island	Oregon	NESCSO
COVID-19 support payments	TBD	TBD	TBD
Other	Yes (e.g., behavioral health screens in primary care settings, programs aimed to increase the number of primary care physicians)	Yes (supplemental workforce payments, including practice coaches, patient educators, patient navigators or nurse care managers)	Yes** (supplemental workforce payments, including practice coaches, patient educators, patient navigators or nurse care managers)

**NESCSO will be finalizing its definition of non-service-based payments in early July. The categorizations here reflects tentative decisions.

Definition of non-service-based payments

- Based on what you just learned, how does the Technical Team wish to recommend a definition of non-service-based payments?

Parallels between the primary care spending target and the cost growth benchmark

- The next three topics discuss how to define total payments, the population, and the payers for the primary care spending target.
- The Technical Team can make recommendations that align with those for the cost growth benchmark. Aligning definitions across the target and the benchmark is advantageous because it:
  - greatly reduces reporting burden;
  - allows for select comparisons to be made between the primary care spending target and the cost growth benchmark, and
  - could be viewed as consistent with EO language: "**set targets within each annual benchmark for increased primary care spending**"
- It may also, however, create non-alignment with other states.

Defining Total Payments

How does one define total payments?

- The calculation of total payments constitutes the denominator for the primary care spending target calculation. There are a few key spending categories (i.e., prescription drugs, lab and imaging services and dental services) that differ in terms of inclusion among states.
- The Technical Team can choose to recommend the same definition of total payments utilized for the cost growth benchmark (i.e., total medical expenses), or a separate definition.

What do others include in their definition of total spending?

Spending Category	CT Cost Growth Benchmark	Rhode Island	Oregon	NESCSO
Prescription drugs	Yes (incl. pharmacy rebates)	Yes (pharmacy rebates TBD)*	No	Yes (pharmacy rebates TBD)**
Lab and imaging services	Yes	Yes	Yes	Yes
Dental services	TBD	No	No	No
Vision services	No	No	No	No
Long-term care	Yes	No	No	No (except Skilled Nursing Facility)

*Rhode Island is refining its primary care spending target definition this summer. It will finalize whether to include pharmacy rebates at that time.
**NESCSO aims to include pharmacy rebates in its definition of total spending, but will finalize its definition after states submit their initial data in July 2020.

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Advantages and disadvantages of different definitions for total spending

- The benefit of including more categories in total spending makes the calculation of total medical expenses more comprehensive.
- However, a narrower definition of total medical expense may be more equitable across payers, as it is limited to service categories that are applicable across multiple markets (e.g., excludes skilled long-term care spending that is concentrated in Medicaid).

Connecticut's definition of total spending

- Based on what you just learned, does the Technical Team wish to recommend utilizing the same total spending definition as that in use for the cost growth benchmark, or a different one?
  - If not the cost growth benchmark methodology, does the Technical Team wish to recommend including total spending for each payer type in the denominator, or exclude Medicaid-only spending?

Raise Hand

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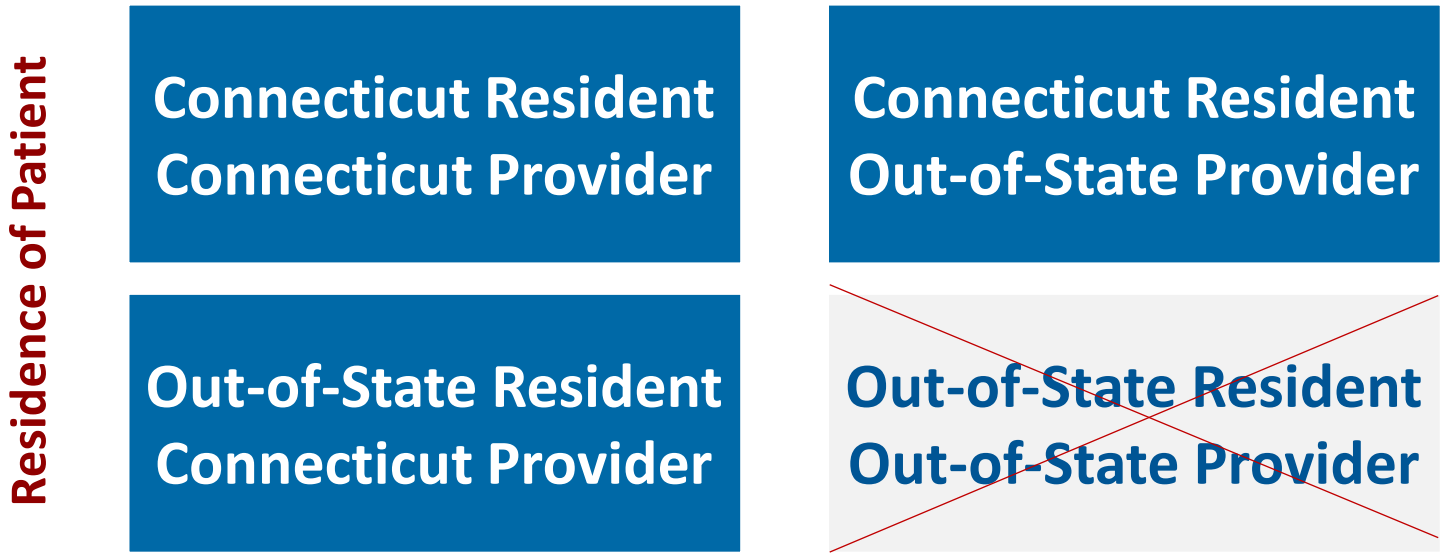
Defining the Population

How does one define the population?

- Similar to the cost growth benchmark, the Technical Team must decide how to define the population based on the location of the resident and the provider. There are three viable options:



How do others define the population?

Resident/Provider Location	CT Cost Growth Benchmark	Rhode Island	Oregon	NESCSO
In-state Resident	Yes	Yes	Yes	Yes
Out-of-state Resident	No	Yes	Yes (only for public employees and educators)	No
In-state Provider	Yes	Yes	Yes	Yes
Out-of-state Provider	Yes	No	Yes (only a few select border areas in WA and ID)	Yes

Connecticut's definition of the population

- Based on what you just learned, does the Technical Team recommend utilizing the same population definition as that in use for the cost growth benchmark, or a different one?
  - If different, how so?

Defining the Payers

How does one define which payers to include?

- The definition of which payers to include can be subdivided into the following two questions:
  1. Should data be collected for payers other than commercial, Medicaid and Medicare?
  2. Should data be collected for all payers, or only payers that meet a minimum size (e.g., covered lives)?

1. Should data be collected for payers other than commercial, Medicaid and Medicare?

- The EO calls for measuring primary care spending across public and private payers in the State, although it is likely only feasible to collect data for Medicaid, Medicare and commercial payers.
- The cost growth benchmark is measuring spending for all residents who are covered through Medicaid, Medicare and commercial payers. It also includes coverage through the Veterans Health Administration and potentially state correctional facilities, although it may be challenging to collect primary care data from all of these additional payers.
- **Based on what you just learned, does the Technical Team wish to collect data only for include Medicaid, Medicare and commercial payers, or does it wish to include additional payers?**
  - **If additional payers, which ones?**

2. Should data be collected for all payers, or only payers that meet a minimum size?

- An analysis performed by Bailit Health with data provided by Paul Lombardo indicated that a handful of CT insurers and TPAs cover or administer coverage for 96% of all commercially covered lives. This suggests that only including insurers that meet a minimum size may accurately capture primary care spending.
- For this reason, Bailit Health recommends that for both the cost growth benchmark and primary care spend target OHS only collect data for insurers and TPAs that meet a minimum size (to be determined).
- **Based on what you just learned, does the Technical Team support this recommendation?**

Setting the Target

How should OHS set the target?

- There are several key questions to consider when setting the primary care spending target, including:

1. What is baseline spending, and how does it differ by market?
2. When calculating the state spending %, should the calculation weight market-specific spending by total market *spending*, or by total market *population*?
3. At what levels should performance be reported beyond state-level (e.g., insurance market, insurer)?

1. What is baseline spending, and what is baseline spending by market?

- In order to determine how much to increase primary care spending to reach 10 percent, the Technical Team will first need to understand how much it is currently spending.
- The Technical Team will need to identify whether it wishes to utilize historical primary care spending data from the PCPCC, Freedman Healthcare, UConn and/or NESCSO to measure baseline spending.
  - It should choose a source for assessing baseline spending that most aligns with its definition of primary care.

2. Should the calculation weight market-specific spending by total market spending or population?

- The EO calls for statewide spending on primary care to reach 10% of total spending by 2025. Given that primary care spending varies widely based on market, and Connecticut has no influence over traditional Medicare, it may not be feasible for all markets to individually reach the 10% target.
- The design of how Connecticut takes into consideration the size of each market, i.e., by total market spending or population, influences the statewide rate.
- **Should the calculation of state-level primary care spending be weighted by total market spending or market population?**

3. At what level(s) should performance be reported?

- Once Connecticut collects data for the primary care spending target, it will need to report progress. Possible levels of reporting include:
  - State-level
  - By insurance market (e.g., Medicaid, Medicare, commercial)
  - By insurer
  - By provider organization / health system

At what levels do other states report performance?

Level of Reporting	CT Cost Growth Benchmark	Rhode Island	Oregon
State	Yes	No*	Yes
Insurance Market	Yes	No*	Yes
Insurer	Yes	No*	Yes
Provider Organization / Health System	Yes	No	No

*Rhode Island only presents statewide insurer market and individual insurer results at stakeholder advisory group meetings. It does not otherwise publicly report data.

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Connecticut's reporting of performance

- Based on what you just learned, at which levels should Connecticut report performance (e.g., state, insurance market, insurer, provider organization/health system)?

Raise Hand

Complementary Analyses to Understand Primary Care Spending

Which complementary analyses should Connecticut perform?

- In order to better understand trends around primary care spending, OHS will need to identify which complementary analyses it should perform. These analyses will be limited by what data are available.
- Examples of feasible analyses to perform include stratifying spending by:
  - Age
  - Comorbidity (e.g., asthma, diabetes)
  - Geography (e.g., zip code)
  - Insurance category (e.g., commercial, Medicaid, Medicare)
- *OHS at this time is unable to stratify data by disability status (not captured in the APCD) or race and ethnicity (not consistently populated in the APCD).*

Connecticut's performance of complementary analyses

- Based on what you just learned, what complementary analyses, if any, does the Technical Team recommend?

Raise Hand

Wrap-Up & Next Steps

Next Meeting: July 29, 2020

- At our next meeting, we will continue our discussion of the primary care spending target.
- We will also discuss a proposed APCD analysis to help inform our understanding of what is driving health care costs in Connecticut.

Meeting Schedule

Meeting #	Date	Time
7	Wednesday, July 29	1-3pm
8	Thursday, August 13	1-3pm
9	Thursday, August 27	1-3pm
10	Thursday, September 24	1-3pm

Appendix

How much does Connecticut spend on primary care? (Freedman Healthcare's analysis)

- OHS contractor Freedman Healthcare used the following methodology to calculate primary care spending:
  - ***Commercial***: utilized 2017 data from the Office of State Comptroller employee benefit plan and NESCSO's core definition of primary care spending; excludes non-claims data
  - ***Medicaid***: utilized 2018 Medicaid data and NESCSO's core definition of primary care spending; includes non-claims data (e.g., care management fees)
  - ***Medicare***: utilized PCPCC's definition of primary care spending; excludes non-claims data (see slide 46)
- According to this definition, Connecticut spent anywhere from 2% - 9% of total medical expenses on primary care, or $33 - $34 PMPM.
  - Total medical expenses did not include Medicaid-specific services (e.g., long-term care, dental).

Source: Freedman Healthcare. "Primary Care Spend Analysis." January 2020.

How much does Connecticut spend on primary care? (Freedman Healthcare's analysis – cont'd)

- Freedman's analysis, using the definitions from the previous slide, found that spending varied by market and based on whether pharmacy spending was included:

	% Total of Medical Expense without Rx	% Total of Medical Expense with Rx
Commercial	6%	5%
Medicaid	9%	9%
Medicare	3%	2%

Source: Freedman Healthcare. "Primary Care Spend Analysis." January 2020.

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How much does Connecticut spend on primary care? (PCPCC's analysis)

- According to the PCPCC report, which leverages 2011-2016 household MEPS data, Connecticut's total spending on primary care was either 3.5 percent or 10.6 percent (!) depending on the definition of primary care employed.
  - **Narrow definition**: restricted to physicians identified in MEPS as practicing family medicine, general practice, geriatrics, general internal medicine and general pediatrics
  - **Broad definition**: also includes NPs, PAs, OB/GYNs, general psychiatrists, psychologists and social workers

Primary care represents 3.5% of total spending

Primary care represents 10.6% of total spending

Source: Patient-Centered Primary Care Collaborative. "Investing in Primary Care: A State-Level Analysis." July 2019.

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How much does Connecticut spend on primary care? (PCPCC's analysis – cont'd)

- MEPS data suggests Connecticut primary care spending varies widely based on payer type and falls below national averages.

Definition of Primary Care	CT/ Nat'l	Private	Medicaid	Medicare	Dually Eligible
Narrow	CT	3.6%	5.4%	2.1%	2.5%
	Nat'l	6.0%	6.0%	4.4%	3.4%
Broad	CT	12.2%	10.3%	3.9%	5.3%
	Nat'l	10.2%	11.2%	6.9%	6.0%

Source: Patient-Centered Primary Care Collaborative. "Investing in Primary Care: A State-Level Analysis." July 2019.

How much does Connecticut spend on primary care? (SIM Evaluation Report analysis)

- The CT SIM Evaluation Report calculated primary care spending using APCD data for FFY 2013-2017 for commercial and Medicare payers.
- The following table summarizes CT's primary care spending for FFY 2017* using this definition:

Market category	Total P.Care Spending	P.Care Spending PMPM	% of Total Health Care Expenses
Commercial	$326 M	$31	5.8%
Medicare	$290 M	$41	2.7%

*Medical and primary care claims data for Medicare were available for FFY 2017 but pharmacy claims data were only available for FFY 2015. We utilized data from both years in order to calculate primary care spending as a percentage of total health care expenditures.

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