Primary Care Subgroup Meeting
October 26, 2021

Meeting Date	Meeting Time	Location
October 26, 2021	1:00 pm – 3:00 pm	Webinar/Zoom

Participant Name and Attendance

Members Present:		
Lesley Bennett	April Greene	Dr. Brad Richards
Rowena Bergmans	Karen Hlavac	Dashni Sathasivam
Dr. Seth Clohosey	Lisa Honigfeld	Marie Smith
Stephanie De Abreu	Ken Lalime	Dr. Elsa Stone
Heather Gates	Dr. Leslie Miller	Dr. Randy Trowbridge
Dr. Alex Geertsma	Dr. Naomi Nomizu	Tom Woodruff
Shirley Girouard	Lori Pennito	
Others Present:		
Michael Bailit, Bailit Health	Grace Flaherty, Bailit Health	Kelly Sinko, OHS
Erin Campbell, Bailit Health	Hanna Nagy, OHS	Jeannina Thompson, OHS
Members Absent:		
Dr. Mario Garcia	Theresa Riordan	Lisa Trumble

Meeting Information is located at: https://portal.ct.gov/OHS/Pages/Primary-Care-Subgroup/Meeting-Agendas

	Agenda	Responsible Person(s)
1.	**Welcome and Roll Call**	**Hanna Nagy, OHS**
	Hanna Nagy called the meeting to order at 1:01PM. Hanna administered the roll call.	
2.	**Public Comment**	**Hanna Nagy, OHS**
	Hanna Nagy invited public comment. None was voiced.	
3.	**Approval of the September 28th Meeting Minutes**	**Hanna Nagy, OHS**
	Karen Hlavac moved to approve the minutes from the September 28th meeting and Lisa Honigfeld seconded. The minutes were approved. Karen Hlavac pointed out a typographical error in Shirley Girouard's comment on the last page of the September 28th meeting minutes. Hanna Nagy said OHS would correct the error in the meeting minutes.	
4.	**Highlights from September 28th Meeting**	**Kelly Sinko, OHS** **Michael Bailit, Bailit Health**
	Kelly Sinko gave introductory comments. Kelly noted that OHS' new Healthcare Benchmark Initiative Steering Committee met for the first time on October 25th and explained that the Steering Committee is an advisory body and not a governing body. Kelly thanked Subgroup members for their input throughout the Roadmap planning process, requested professional demeanor during the meeting, and reminded the Subgroup to use Zoom's raise hand function. **Discussion:** • Shirley Girouard asked how the Steering Committee's activities would interface with the Primary Care Subgroup's activities. Kelly Sinko said the Steering Committee was replacing the OHS Technical Team because OHS wanted to ensure it engaged directly impacted stakeholders in implementing the Governor's Executive Order. Kelly Sinko said the Primary Care Subgroup would remain focused on the Roadmap and she did not see a conflict in the roles of the two bodies.	

Michael Bailit added that Primary Care Subgroup was much more narrowly focused and technical in orientation than the Steering Committee, which has a much broader scope and charge.

- Elsa Stone asked about the Steering Committee's composition. Kelly Sinko said she would share its membership after the meeting.

Michael Bailit summarized the Subgroup's discussion during the September 28th meeting. Michael said the Subgroup continued its review of OHS' primary care payment models and reviewed four alternative payment models to the proposed strawman.

Michael reviewed the October 26th meeting agenda. Michael said the meeting would focus on (1) reviewing primary care spend data and making recommendations to OHS for primary care spending targets for 2022-2024, and (2) reviewing and providing feedback on a high-level Roadmap implementation plan that outlined responsibilities of OHS, payers and practice teams over the next two years.

5.	**Continuation of Roadmap Development**	**Michael Bailit, Bailit Health** **Erin Campbell, Bailit Health**

Primary Care Spend Target

Michael Bailit reminded the Subgroup that Executive Order No. 5 directed the Executive Director of OHS to set annual targets for increased primary care spending as a percentage of total health care expenditures, to reach a target of 10% by calendar year 2025.

Michael said that when the OHS Technical Team was considering primary care spending targets in 2020, it was unclear what Connecticut was spending on primary care, so the Technical Team recommended, and OHS adopted, a standard methodology for defining and measuring primary care longitudinally (a narrow definition for target purposes and a broad definition for monitoring purposes). Michael reviewed the two adopted definitions, including definitions of "primary care provider" and "primary care services", and the primary care spend data analysis methodology.

Discussion:

- Shirley Girouard asked whether the individual patient was the unit of analysis. Michael clarified that total primary care payments were the unit of analysis, generally over one-year periods.
- Marie Smith asked whether pharmacy payments were included. Michael confirmed that pharmacy payments were included in the denominator (total spending) but not in the numerator (primary care spending).

Michael shared the findings of the primary care spend data analysis (see below). Michael noted that one insurer was in the process of resubmitting its data and it was possible but not likely that percentages would change as a result of the resubmission.

Market	2018 Primary Care Spend Percentage	2019 Primary Care Spend Percentage
Commercial	5.2%	5.1%
Medicaid	9.2%	9.4%
Medicare FFS	2.5%	3.1%
Medicare Advantage	5.8%	5.2%
Total	**5.4%**	**5.5%**

Discussion:

- Shirley Girouard said she found it difficult to understand the data because it did not include spending for services delivered by specialists. Michael acknowledged that the estimate was measuring the percentage of payments going to primary care providers for primary care services, and did not include spending on primary care services delivered by non-primary care providers.

Michael explained that the Technical Team set a conservative target for 2021 of 5.0%. Michael said the Subgroup's task was to recommend to OHS what the target should be for 2022, 2023, and 2024 (for 2025 the value had already been set at 10% per the Governor's Executive Order).

Michael shared an example of what Rhode Island did in a similar circumstance when the state set a primary care spending target. Michael said Rhode Island had a baseline of 5% for primary care spending and a regulatory requirement of 10% and elected to require a one percentage point increase for each of five years.

Michael presented two options for the Subgroup's consideration for CT's primary care spend for 2022-24:

1. ***Option 1****: Divide the difference between 2019 baseline performance and the 10% 2024 target by four, increases of 1.1% per year (6.6%, 7.7%, and 8.8%). This approach would assume 2021 performance equals 2019 performance.*

Discussion:

- Shirley Girouard said increasing payments to primary care providers to 10% was not the same as increasing payments for primary care services delivered by primary care and specialty care providers. Michael confirmed Shirley's statement.
- Elsa Stone asked if OHS would regulate the target. Michael said no, the Governor's Executive Order set a voluntary target. Elsa asked how insurers felt about the target. Michael explained OHS had had many meetings with insurers and some have voiced stronger levels of support than others. Kelly Sinko added that one of the reasons OHS assembled the Healthcare Benchmark Initiative Steering Committee was to engage insurers and get buy-in. Elsa further elaborated that all insurers would need to commit to ensure success.
- Rowena Bergmans pointed out that the primary care spending definition did not align with what was required under the core functions, specifically the expanded care team and care management recommendations. Rowena also said contract negotiations do not necessarily happen yearly. Michael agreed that the primary care spend definition should align with the practice team core functions – for example, spending for care management and care coordination should count towards the primary care spending definition.
- Ken Lalime asked whether there were limits on the percentage of spending that could go towards primary care by market. Michael clarified that there were no caps on market-level primary care spending.
- Shirley Girouard asked about Rhode Island's enforcement mechanisms. Michael said the regulation was for the commercial market and the primary enforcement mechanism was a requirement that commercial insurers report annually on primary care spend. In addition, the state had the ability to do analyses using its All-Payer Claims Database.
- Elsa Stone wondered if Medicaid's 9% primary care spending was related to the small number of specialists who accept Medicaid. Michael said that could be the case, but it also could be related to price because Medicaid pays more for some services and less for others. Michael added that the health status of the population was also a contributing factor in the primary care spend rates, and he speculated that the Medicare FFS population was sicker and used more specialty services, thus driving up spending in the measure denominator. Elsa suggested that insurers contribute funds to

a pool to support primary care as they have done for vaccines. Michael said theoretically that was possible.

Michael presented the second option for the primary care spending target:

1. ***Option 2****: Make initial increments smaller than later increments to give commercial insurers more time to pivot (6.0%, 7.0%, and 8.5% for years 2022-24).*

Discussion:

- Elsa Stone said the advanced primary care model would require practices to make significant up-front expenses.
- Ken Lalime said that simplicity should rule.
- Shirley Girouard said the group should not make a recommendation until they had a better understanding of what was in the numerator of the primary care spending definition.
- Alex Geertsma asked whether Rhode Island saw a relationship between increased payments in primary care, overall costs, and quality. Michael said Rhode Island saw a doubling of investment in primary care but added that Rhode Island also had a cap on hospital price growth. Alex asked whether the growth was tied to global payments or improved health outcomes. Michael said there was no formal evaluation of the direct impact on quality, but noted that that Rhode Island did not see a market decrease in quality.
- Lesley Bennett said she was very concerned about the core functions and the proposed models and their ability to protect patients. Lesley said there were very few contractors who could monitor the program.
- Randy Trowbridge said he was unimpressed with the models in Rhode Island, emphasized the need for strong patient-clinician relationships, and advocated for functional medicine. Michael reminded the Subgroup that the question at hand was how to set the primary care spend targets. Randy said the primary care spending numbers should be larger up front.
- Kelly Sinko added that once a practice begins working towards the core functions they would begin receiving enhanced payments.
- Brad Richards said he preferred Option 1 because of its simplicity and larger upfront payments. Brad agreed that increased spending alone would not make a difference and emphasized the importance of a more holistic view of the Roadmap, including the core functions and payment mechanisms.

6.	**Roadmap Implementation Planning**	**Erin Campbell, Bailit Health**

Erin Campbell said the Roadmap implementation plan would describe who would be responsible for what actions and by when to successfully implement the functions and processes to advance primary care as defined by the Subgroup. Erin presented the draft year one (2022) and year two (2023) implementation activities and requested feedback from the group.

Discussion:

- Shirley Girouard asked about the purpose of the implementation plan. Erin Campbell said the plan was about implementing the various Roadmap strategies recommended by the Subgroup.
- Lesley Bennett asked whether OHS had identified a contracted third party. Erin Campbell said OHS had not identified a contracted third party. Lesley expressed concern. Michael Bailit said the Roadmap was still under development and practices would not be asked to do anything until the Roadmap implementation steps were completed in a way that was fair and appropriate to the practices. Lesley suggested they create a list of contracted third parties that know how to do this work. Michael said OHS would need to follow its state procurement regulations.

	• Elsa Stone asked how insurers would be monitored. Erin said OHS would collaborate with payers on their commitments and progress. • Alex Geertsma said that, regarding contracted third parties, it was important to keep in mind that primary care in pediatrics was different than internal medicine and family medicine. • Marie Smith said some Subgroup participants had previous experience with OHS in practice transformation using a single contractor and suggested changing the implementation plan language to "OHS contracted third parties/subcontractors." Marie said the issue with the single contractor was that the contractor had experience in one area but were asked to execute on nine functions. Michael said he would love to hear more about the prior experience. • Stephanie De Abreu asked about the expectation that insurers would be providing funding for third-party contractors. Erin said the recommendation was for the insurers to fund practice coaching. • Naomi Nomizu differentiated between a system for practice transformation and system for accountability. Michael acknowledged that there was a big difference between providing coaching support and ensuring accountability. • Dashni Sathasivam said she did not see how the activities support practices in being more equitable or providing more equitable care (e.g., through coaching, data collection, equality measures). Dashni emphasized that increasing payments did not guarantee better quality or more equitable care. Erin noted that some of the core functions had an equity lens, however, this should be further considered as the operational details of the core functions are developed.	
7.	**Next Steps and Wrap-Up**	**Erin Campbell, Bailit Health** **Hanna Nagy, OHS**
	Erin Campbell said that OHS would share a draft of the Roadmap in advance of the November meeting and asked the group to be ready to provide feedback. Hanna Nagy said the next Primary Care Subgroup meeting was scheduled to take place November 16th at 1:00pm.	
8.	**Meeting Adjournment**	**Hanna Nagy, OHS**
	Elsa Stone made a motion to adjourn the meeting. Ken Lalime seconded the motion. There were no objections. The meeting adjourned at 2:35pm.	