Primary Care Subgroup Meeting
November 16, 2021

Meeting Date	Meeting Time	Location
November 16, 2021	1:00 pm – 3:00 pm	Webinar/Zoom

Participant Name and Attendance

Members Present:		
Lesley Bennett	Dr. Shirley Girouard	Dashni Sathasivam
Rowena Bergmans	April Greene	Marie Smith
Dr. Seth Clohosey	Karen Hlavac	Dr. Elsa Stone
Stephanie De Abreu	Lisa Honigfeld	Dr. Randy Trowbridge
Dr. Mario Garcia	Ken Lalime	Lisa Trumble
Heather Gates	Dr. Naomi Nomizu	Michele Wolfsberg
Dr. Alex Geertsma	Dr. Brad Richards	Tom Woodruff
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. Leslie Miller	Theresa Riordan	

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**	**Kelly Sinko, OHS**
	Kelly Sinko called the meeting to order at 1:02 PM. Hanna Nagy administered the roll call.	
2.	**Public Comment**	**Kelly Sinko, OHS**
	Kelly Sinko invited public comment. None was voiced.	
3.	**Approval of the October 26th Meeting Minutes**	**Kelly Sinko, OHS**
	Lesley Bennett asked that the October 26th meeting minutes be amended to reflect that in response to her request for a list of contractors capable of monitoring the OHS developed programs, Michael Bailit said a list of contractors could not be shared because of RFP restrictions. Kelly Sinko said OHS would amend the meeting minutes to reflect this and offered to schedule a meeting with Lesley to explain the RFP requirements. Karen Hlavac moved to approve the minutes from the October 26th meeting and Lisa Trumble seconded the motion. The minutes were approved (as amended).	
4.	**Review Primary Care Spending Target Recommendations**	**Michael Bailit, Bailit Health**
	Michael Bailit shared that since the last Subgroup meeting OHS received updated information for Medicaid's primary care spend calculation. Michael said the updated percentage for Medicaid primary care spending as a percentage of total TME in 2019 was 7.9 percent for 2019, which was lower than the 9.4 percent figure that was reported during the October 26th Subgroup meeting. Michael said that, as a result, the statewide (cross-market) percentage for 2019 was 5.3 percent, rather than 5.5 percent. **Discussion:**	

- Elsa Stone asked whether out-of-pocket spending was included in the primary care spend estimate. Michael said out-of-pocket spending for individuals without insurance coverage or who otherwise paid completely out-of-pocket was not captured in the calculation.
- Ken Lalime asked whether the primary care spending estimate used the allowed amount. Michael confirmed that the estimate used the allowed amount.
- Alex Geertsma asked why there was a discrepancy in the Medicaid calculation. Michael said the prior calculation did not follow the specifications.
- April Greene recommended OHS use a broader primary care spending definition that included urgent care, retail primary care, and telemedicine. Michael said he thought the definition included telehealth visits but said OHS would confirm. Michael said OHS could reconsider the definition in the future, but the OHS Technical Team recommended and OHS approved the current definition in 2020. Michael said OHS would bring this up with the Steering Committee and consider possible changes to the primary care spend definition.

Michael reminded the Subgroup that during the last meeting OHS presented two possible options for primary care spending targets for 2022-24. Michael reviewed Option 1, which divided the difference between the 2019 baseline performance and the 10% 2024 target by four and said Option 1 had been modified to reflect the updated baseline performance estimate. Michael then reviewed Option 2, which made initial increments smaller than later increments to give commercial insurers more time to increase primary care investment. Michael said a few Subgroup members expressed a preference for Option 1 During the October meeting due to the simplicity of the calculation and larger upfront payments that would occur (if payers met the target). Michael said other members did not voice a preference and some didn't feel comfortable stating a preference.

Michael presented a third option for Subgroup consideration. Michael said Option 3 would set the 2022 target at 5.3%, the baseline level calculated for 2019, and make near equal increases in the target for years 2023, 2024, and 2025.

Discussion:

- Alex Geertsma asked whether certain markets would be expected to increase primary care spending faster or slower than other markets, depending on their baseline spending. Michael said markets that have lower primary care spending would need to increase primary care spending more than markets that have a higher baseline percentage. Alex said that Medicaid may not have an incentive to increase spending given their higher baseline. Michael said yes, maybe Medicaid would not have an incentive in the initial year, but then Medicaid would need to increase in 2024 and 2025. Alex asked whether the calculation or targets were risk-adjusted. Michael said they were not risk-adjusted.
- Alex Geertsma asked about the Medicaid PCMH+ program. Brad Richards said the Roadmap core functions were aligned with the PCMH+ program and said practices would not be expected to do more without more resources. Alex said the performance measures for PCMH+ seemed to be proxies for the core functions, however, he was not convinced PCMH+ practices have made all the changes they were supposed to and therefore wouldn't meet the requirements for the core functions. Brad acknowledged more work was needed to align with the core functions and there were opportunities for improvement in performance measurement.
- Stephanie De Abreu asked whether the primary care spending targets were reviewed to ensure there would be a benefit to the added investment. Michael said he thought, personally, that the Roadmap should include a plan to define specific metrics for the value expected as a result of the increased investment and the application of the core functions.

	• April Greene agreed with Stephanie and expressed skepticism that increasing primary care spending would decrease overall spending. April recommended that OHS establish a total cost of care benchmark to assess the overall efficacy of the proposed model and suggested that any additional upside payments made to primary care practices in fully insured products be at-risk. Michael asked April how a total cost of care benchmark would differ from the state's cost growth benchmark. April said she did not see a total cost of care benchmark tied to the primary care benchmark for increased spending. Michael said the Governor's Executive Order established a cost growth benchmark with the expectation that overall spending should slow and primary care investment should increase. April said she hadn't seen benchmarks in this light, and without a total cost of care comparison, self-insured employers would be unlikely to support the approach. April said the primary care target's timing was an issue and moving toward a target would take a minimum of three years because contracts are established every three years. • Lesley Bennett said she was reluctant to approve any of the options until she was assured that patient care would improve. Lesley said other states have approached primary care transformation differently. • Shirley Girouard agreed with Lesley Bennett and said she did not have enough information about where the increased funding would go to approve any of the options. • Tom Woodruff asked what the PMPM spend was for primary care and pointed out that the state's health plan may have higher PMPM spending than aggregate spending. Tom suggested having different targets for different groups. Michael said the Executive Order did not specify targets for specific groups and spending could be higher for some groups than others. • Lisa Trumble acknowledged the Subgroup's reluctance to support any of the options but said she did not see a problem with recommending targets to increase primary spending while OHS worked with the community to develop strategies to increase spending, especially if there were no ramifications for not meeting the targets. Michael asked whether Lisa preferred any of the options. Lisa said did not have a strong preference but said Option 3 was a reasonable place to start. • Rowena Bergmans suggested quantifying the added expense of core functions (e.g., community health workers) to help guide the targets. Michael said some of the core functions have anticipated increased resource investments (e.g., care coordination). Michael also mentioned a past project that modeled staffing for a high performing primary care practice under difference scenarios, which could be shared with the Subgroup. Michael asked Rowena if she preferred any of the three options. Rowena said she did not have a preference yet but said if transformation is expected it should be funded. • Alex Geertsma asked if the Roadmap specified having a body like the Subgroup regularly review the plan. Michael said that although the new Healthcare Benchmark Initiative Steering Committee would be a resource, a primary care-focused advisory group was not specified in the Roadmap. Michael invited Alex to send a more detailed recommendation to OHS. • Stephanie De Abreu recommended that more work be done to choose appropriate percentage targets, rather than choosing arbitrary targets. Michael said OHS was obligated to establish the annual cost growth targets by 2022. Kelly Sinko reminded the Subgroup that a target was already set for 2021 (5%) and 2025 (10%) and OHS would appreciate the Subgroup's input on the best intervals to reach 10%. • Alex Geertsma clarified whether the first year's increase included initial administrative and educational costs. Michael said the Roadmap specified a couple years of technical assistance, the cost of which would be shared by payers. Michael clarified that the technical assistance costs would not be included in the primary care spending target calculation.	
5.	**PCSG Feedback on Draft Roadmap**	**Michael Bailit/Erin Campbell,**

		Bailit Health

Erin Campbell reminded the Subgroup that the Roadmap was meant to reflect the group's conversations since April 2021. Erin said the OHS' Roadmap was multi-payer in orientation, with a commercial market-focus but aligned with Medicaid. Erin said the Roadmap was intended to be complementary to the primary care spend target and the cost growth benchmark.

Erin said the Roadmap strategies included (1) core function expectations of primary care practice teams, (2) the resources and supports to help practice teams master the core function expectations, and (3) methods to assess and recognize practice team performance, and (4) common parameters for and the provision of voluntary payment options for primary care.

Discussion:

- Lesley Bennett asked whether OHS planned to run a pilot project. Erin said there were currently no plans to run a pilot. Lesley recommended running a pilot in 2022 to work out the plan's details. Lesley questioned OHS' and Bailit Health's experience in and qualifications for primary care transformation.
- Kelly Sinko acknowledged that the Roadmap details needed to be further developed in 2022. Lesley Bennett said she was not confident OHS had a plan or that OHS or any other Connecticut state agency, including DPH, was capable of implementing the Roadmap.
- Mario Garcia said that DPH was on board with OHS' primary care transformation initiative and was following the Roadmap development process very closely.

Erin asked for feedback on the Roadmap, section-by-section. Erin invited the Subgroup to share written feedback in addition to verbal comments during the meeting.

I. Background and process

Discussion:

- Dashni Sathasivam noted that the introduction cited staff shortages and recruitment challenges but lacked mention of workforce diversity. Dashni also suggested defining the word "equity" and noted that racial equity was not brought up in the Roadmap.

II. Roadmap Elements: Core function expectations of primary care practice teams

Discussion:

- Lisa Honigfeld said she did not like core function #11. Lisa said she thought it was passive and missed the mark in understanding that health and wellness depend on more than just being aware of community resources, but rather working in collaboration with community resources and being better integrated with community resources.
- Brad Richards said he agreed with the need for better integration of community resources but acknowledged the feasibility challenges.
- Lesley Bennett suggested revising core function #4 to make use of excellent care coordination programs in other states. Erin asked Lesley to share examples of specific programs and Lesley said she could share models in California.
- Alex Geertsma asked whether any practices had expressed interest in being involved as early adopters of the process. Erin said OHS had conversations with practices during the Roadmap development process and has estimates of the number of practices who might want to participate but did not ask for commitments.

	• Elsa Stone asked about status of insurer support. Michael agreed with Elsa that payer support was essential. Kelly said OHS engaging with executive leadership and gaining insurer support was part of the implementation plan. • Dashni Sathasivam suggested adding details about stakeholder engagement in section 2.1, for the sake of transparency. Dashni also said that OHS could note where there were opportunities for growth or improvements in the process. • Naomi Nomizu said she felt the Subgroup owed some courtesy to the process and to OHS. Naomi added that she was a part of a health system that was already planning to transform primary care, in part because FFS no longer worked for primary care. Naomi said Medicare was already moving toward a total-cost-of-care model. II. Roadmap Elements: Resources and supports to help practice teams master the core function expectations • No discussion II. Roadmap Element: Methods to assess and recognize practice team performance • No discussion II. Roadmap Elements: common parameters for and the provision of voluntary payment options for primary care **Discussion:** • Dashni Sathasivam expressed concern about risk-adjustment, specifically that it did not consider social risk. Michael said the science on social risk adjustment was not very good yet and said he feared doing it in a way that would actually be hurtful. Dashni said current risk-adjustment methodologies also had potential to do harm. • Rowena Bergmans noted the potential to use Z-codes to enhance current risk-adjustment methods. Michael said using Z-codes could be possible but would need to be preceded by a big research project. • Randy Trowbridge shared the clinical challenges of caring for patients with high social-risk and fewer resources. III. Structural barriers to high-quality primary care and related actions • No discussion IV. Roadmap implementation plan • No discussion V. Primary care workforce development • No discussion	
6.	**Next Steps and Wrap-Up**	**Erin Campbell, Bailit Health/ Kelly Sinko, OHS**
	Erin Campbell said that OHS would release the Roadmap for public comment in December and continue ongoing engagement with stakeholders to seek final input. Erin said the Roadmap would be finalized once public and stakeholder feedback was reviewed and addressed. Kelly Sinko thanked the Subgroup for their feedback and participation. Kelly said the Subgroup would not meet in December because OHS would be collecting public comments on the Roadmap.	

Primary Care Subgroup Meeting
November 16, 2021

7.	**Meeting Adjournment**	**Kelly Sinko, OHS**
	Rowena Bergmans made a motion to adjourn the meeting. Shirley Girouard seconded the motion. There were no objections. The meeting adjourned at 2:30pm.	