Office of Health Strategy (OHS) Roadmap for Strengthening and Sustaining Primary Care

Connecticut Office of Health Strategy

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1 Introduction

Governor Lamont's vision for improving healthcare system performance is rooted in Executive Order No. 5, which he signed in January 2020. The Executive Order highlights three policy priorities for improving healthcare system performance in Connecticut (CT):

1. Improve affordability of health care
2. Improve quality of care, equity and population health status
3. Support the state's primary care infrastructure

This document focuses on the governor's third priority, supporting the state's primary care infrastructure. Primary care, the foundation of our nation's healthcare delivery system, is in trouble across the United States. There are multiple indicators of this trouble: fewer medical school students entering primary care,[1] an aging primary care physician workforce,[2] and high levels of burnout causing clinicians to leave the workforce.[3,4]

Supporting the state's primary care infrastructure necessitates action across three dimensions. First, it requires increased investment in primary care. While primary care clinicians are considered the bedrock of the health care delivery system, primary care physicians are among the lowest compensated physicians,[5] and they often lack funds to augment their practices with other complementary health professionals. Executive Order No. 5 calls for primary care spending across all payers and populations to reach a target of 10 percent of total healthcare expenditures by calendar year 2025. Analysis completed by OHS in October 2021 found that in 2019, only 5.1 percent of the commercial payments in Connecticut went to primary care.[6] This increased investment will be an important step towards rebalancing Connecticut health care system investment towards primary care.

Second, action is required to expand the primary care workforce. Connecticut primary care organizations report staff shortages and enormous difficulty in recruitment. While not directly addressed through the Executive Order, OHS is committed to collaborating with other state

[1] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983
[2] Wilkinson E, Bazemore E, Jabbarpour Y. Ensuring Primary Care Access in States with an Aging Family Physician Workforce. *Am Fam Physician*. 2019 Jun 15;99(12):743. PMID: 31194480.
[3] Agarwal SD, Pabo E, Rozenblum R, Sherritt KM. Professional Dissonance and Burnout in Primary Care: A Qualitative Study. *JAMA Intern Med.* 2020;180(3):395–401. doi:10.1001/jamainternmed.2019.6326
[4] Debora Goetz Goldberg, Tulay G. Soylu, Victoria M. Grady, Panagiota Kitsantas, James D. Grady and Len M. Nichols. Indicators of Workplace Burnout Among Physicians, Advanced Practice Clinicians, and Staff in Small to Medium-Sized Primary Care Practices. *The Journal of the American Board of Family Medicine* May 2020, 33 (3) 378-385; DOI: https://doi.org/10.3122/jabfm.2020.03.190260
[5] https://www.fiercehealthcare.com/practices/residents-salaries-influence-choice-specialties-who-makes-most-least
[6] OHS October 26, 2021 Primary Care Subgroup presentation

agencies and Governor Lamont's Office of Workforce Strategy to work on resolving this pressing need.

Third, action is needed to help Connecticut's dedicated primary care professionals to better meet the needs of their patients. This necessitates a strategy to complement the primary care spending targets so that increased primary care investments yield meaningful and measurable benefits. OHS' *Roadmap for Strengthening and Sustaining Primary Care ("Roadmap")* lays out this strategy, with actionable steps for more effective, efficient, and equitable primary care to better meet the needs of patients and sustain primary care professionals. Learning from the state's prior CMS-funded State Innovation Model (SIM) experience, OHS chose to pursue a strategy that is similarly inspired but comparatively more modest and flexible in scope so that it can be implemented in a timely fashion and achieve the governor's goals.

This Roadmap focuses on four key steps to strengthen and sustain primary care:

1. Establish core functional expectations of primary care practice teams.
2. Apply resources and supports to help practice teams master the core function expectations.
3. Develop methods to assess and recognize practice team performance.
4. Make available voluntary primary care alternative payment models, beyond fee-for-service (FFS), to reimburse primary care.

OHS collaborated with the CT Department of Social Services (DSS) to ensure the Roadmap is closely aligned with Connecticut Medicaid's PCMH+ program (refer to Appendix B for alignment between programs). DSS and OHS will continue to collaborate throughout the implementation of this Roadmap to maximize alignment between Medicaid and commercial payment models.

OHS' Roadmap assumes (1) commercial insurers will increase primary care spending up to the governor's target and take action to aid implementation of the Roadmap, and (2) primary care practices[7] that choose to participate in OHS' primary care Roadmap and adopt the prescribed core functions will receive enhanced primary care payments[8] for doing so. The Roadmap further describes requirements of practices that choose to participate. OHS plans to work with providers and payers to encourage participation in the implementation of the Roadmap and aligned models that advance primary care.

2 OHS' Roadmap

2.1 Background

In February 2015, the State initiated a multi-year primary care modernization initiative as part of its broader SIM work. Extensive, inclusive and thoughtful work was performed to advance an improved primary care system for Connecticut. While many recommendations were not

[7] See Appendix A for OHS' definition of primary care
[8] Enhanced payments are defined as increases to existing primary care payments and/or new payments.

realized, this prior body of work and related experience provided a foundation for OHS' Roadmap.

OHS began work in Spring 2021 with its advisory Primary Care Subgroup ("PCSG", refer to Appendix C for membership) to develop this Roadmap. To guide its work, the PCSG (1) recommended, and OHS adopted, the National Academies of Science, Engineering, and Medicine ("National Academies") updated definition of high-quality primary care[9] (see Figure 1) and (2) identified highest priority objectives for a strengthened primary care system:

> *"High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."*

Figure 1: OHS' adopted definition of high-quality primary care

1. Patients easily access comprehensive, patient-centered, equitable, evidence-based care that supports their health.
2. Primary care practices are supported in their efforts to deliver such care through a) removal of structural impediments to delivery of good care, b) technical assistance on best practice care and c) payment levels and structures.
3. Primary care professionals and team members find their daily work, on balance, professionally gratifying.

The National Academies recently published a report on rebuilding primary care, which noted that high-quality primary care forms the foundation of a high-functioning health system and is key to improving the experience of patients and care teams, as well as population health, and reducing costs.[10]

Table 1 highlights the benefits of a strengthened primary care system for both patients *and* practices.

Table 1: Benefits to patients and practices from strengthening primary care

Patients	Practices
Increased access ▪ More time and attention for individual patients	**More time for patient care** ▪ Increased opportunities to understand patient goals and needs ▪ Ability to focus on quality outcomes

[9] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

[10] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

Patients	Practices
▪ Convenience of various types of appointments with increased access to practice **Whole-person care approach** ▪ More time and resources to address social risk factors ▪ Expanded care team, including care coordinators whose role is in part to help address social needs through linkages and coordination with social services, health collaboratives, and other community-based resources ▪ Improved collaboration across care providers **Early identification and intervention** ▪ Focus on prevention and wellness ▪ Improved health and reduced illness burden	**Improved professional capabilities** ▪ e.g., data analytics, quality improvement **Multi-payer alignment** ▪ Limited number of quality measures ▪ Reduced administrative burden **Flexibility in practice design and workflow** ▪ Services to support patient needs ▪ Team-based approach **Predictable financing**

2.2 Roadmap Development Process

From April through November 2021, OHS met monthly with the PCSG and facilitated a multi-step process to develop the Roadmap. This process was informed by conversations with CT primary care practices, consumer advocates and groups, and insurers during the initial phase of work. The process focused first on topics related to an improved primary care delivery model before advancing to discussions on options for a primary care payment model(s). Table 2 highlights the multi-step process.

Table 2: Multi-step process used to facilitate Roadmap development

Process Step	Description
1. Establish highest priority objectives for a strengthened primary care system	The 3-5 highest priorities of a strengthened primary care system; not an all-inclusive list.
2. Adopt an advanced primary care practice model	Describes core, essential practice function expectations for advancing primary care.
3. Decide how practices will be supported in adopting the practice model, and by whom	Describes how practices will be supported in mastering the core practice team functions identified in #2 above. Examples may include learning collaborative(s), practice coaching, self-taught with learning aids, or a combination.
4. Adopt a program for recognizing practice model adoption	Describes the process for confirming practices have mastered the core practice team functions,

Process Step	Description
	necessary for support increased primary care investment.
5. Adopt a voluntary payment model(s)	Supports reimbursement for the core practice team functions, sustains practices and aligns with objectives for high-value care.
6. Adopt an implementation plan	Describes who will be responsible for doing what, and by when. Involved stakeholders should support the plan; commercial payers must commit to it.
7. Define a measurement and evaluation plan. *Note: this step will be completed in early 2022, following completion of the Roadmap.*	A plan to determine that the highest priority objectives were achieved, without any unintended adverse consequences.

2.3 Stakeholder Engagement

Throughout the Roadmap development process, OHS solicited broad input on the evolving Roadmap from a wide array of stakeholders to understand different perspectives and to make certain the Roadmap reflected CT's current environment, ensured a patient-centered and patient-driven approach, supported primary care practices of all sizes, and would be feasible for stakeholders to implement. While OHS' PCSG represented a diverse group of stakeholders, OHS also solicited input on the Roadmap from the following additional stakeholders:

- **Consumer Advocates:** CT Chapter of the National Association of Hispanic Nurses, Department of Public Health Medical Home Advisory Council, OHS Consumer Advisory Council, OHS Community Health Subgroup and Health Enhancement Communities
- **Providers**: Bristol Hospital, Community Health Center Association of CT, Community Health Center Inc., CT State Medical Society – IPA, Eastern CT Health Network Medical Group, Hartford HealthCare Integrated Care Partners, Medical Professional Services, Northeast Medical Group, SOHO HEALTH, Starling Physicians, Trinity Health of New England Medical Group, Yale New Haven Health
- **Medical Societies**: Connecticut Chapters of the Academy of Family Physicians, Advanced Practice Registered Nurse Society, American College of Physicians, American Academy of Pediatrics
- **Payers**: Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim, UnitedHealthcare
- **State Agencies**: CT Insurance Department, CT Department of Social Services, CT Department of Public Health, CT Office of the State Comptroller

In December 2021, OHS released the Roadmap for public comment. Refer to Appendix D for a summary of public comments.

2.4 Roadmap Elements

The Roadmap has four central elements intended to strengthen and sustain primary care:

1. Core function expectations of primary care practice teams.
2. Resources and supports to help practice teams master the core function expectations.
3. Methods to assess and recognize practice team performance.
4. Voluntary primary care alternative payment model to fee-for-service (FFS) payment.

2.4.1 Core Function Expectations of Primary Care Practice Teams

During the initial phases of Roadmap development, OHS heard from members of the Primary Care Subgroup that an increased investment in primary care should be accompanied by improved performance and increased accountability of primary care practices. In response, OHS asked the PCSG to consider what constitutes high-quality primary care, and how the increased investment should be used. The PCSG helped shape the definition of 11 core functions foundational to the delivery of high-quality primary care that can be supported by increased primary care payments and primary care alternative payment methodologies.

OHS shared and solicited feedback on earlier drafts of the core functions with stakeholders identified in Section 2.3, Stakeholder Engagement. All stakeholder feedback was considered prior to finalizing the core functions. The core primary care practice team functions are summarized below.

1. Care delivery is centered around what matters to the patient, developing **trusted relationships** with patients, making them feel heard and listened to, and instilling person-centered practices from the front desk to post-visit follow-up.
2. Care delivery is **team-based**, with the practice team consisting of a range of clinicians and non-clinicians, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.
3. Practice teams formally **designate a lead clinician** for each patient. That person fosters a continuous, longitudinal relationship. A lead clinician is a designated medical professional within a practice team who holds lead responsibility for an individual patient relationship e.g., a physician or APRN.
4. Practice teams coordinate care for its patients between visits and across the continuum of care. To support such work, the practice team includes a) **qualified, embedded clinical care management personnel** to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and b) **embedded non-clinical care coordination personnel** to connect all patients with community supports to address social risk factors, and work with families and other caregivers. "Embedded" refers to staff who are dedicated to specific practices. They may be physically located full or part-time at the

practice site, or should the practice site not afford sufficient physical space, physically located elsewhere.*

5. **Behavioral health** is integrated into the practice team through a) mental health clinicians who are members of the practice and provide assessment, brief treatment and referral, and b) through screening and referral for substance use treatment.*
6. Practice teams deliver "**planned care**" at every visit, including reviewing the patient's medical record prior to the visit and addressing all identified issues during the visit.
7. Care is easily **accessible and prompt**, using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is accessible to persons with disabilities and is culturally and linguistically competent.
8. Care delivery follows **evidence-based** guidelines for prevention, health promotion and chronic illness care, supported by electronic health record (EHR) clinical decision support.
9. Practices **engage and support** patients in healthy living and in management of chronic conditions.
10. The practice team **utilizes patient information** in conjunction with **data** from an EHR when utilized by the practice, HIE, pharmacies and payers to identify patient care needs, monitor change over time, and inform targeted **quality and equity improvement** activity, including design and implementation of quality improvement plans.
11. The practice team identifies **social risk factors** affecting its patients and is knowledgeable about **community resources** that can address social needs.

*Alternative approaches are permitted on an exception basis for very small practices and *may* include exclusively virtual care delivery by some practice team members (e.g., care management, care coordination, behavioral health), formal referral arrangements instead of embedded care for integrating behavioral health into the practice, and shared care management and coordination responsibilities within a practice. Alternative approaches will be defined through subsequent OHS guidance.

2.4.2 Resources and Supports to Help Practice Teams Master Core Function Expectations

To maximize the success of Roadmap implementation, OHS anticipates practice teams may need time-limited support to help them implement and master the core practice team functions. Not all practices need the same level of support, and some may elect to receive none.

OHS' approach to practice supports includes a blended approach of primary care practice team coaching and learning collaborative(s).

2.4.2.1 Practice Team Coaching

Practice teams that choose to participate in OHS' primary care Roadmap, adopt the prescribed core functions, and receive enhanced primary care payments for doing so must demonstrate commitment to and mastery of all 11 core practice team functions to qualify for enhanced payments. Practice teams are offered access to practice coaching to help them master the core

practice team functions. Practice coaching is primarily provided by a qualified OHS-contracted third party(ies), with shared funding envisioned to be provided by the state's largest commercial insurers on a pro rata basis (i.e., based on the insurer's market share).

Practice teams may instead elect to receive practice coaching from a commercial insurer they already have an existing relationship with if the commercial insurer also agrees to provide that support. Practices teams that are part of large organizations may also choose to receive support through their organizational resources. If one of these alternative sources of practice coaching is preferred by the practice team instead of the OHS-contracted third party(ies), then in order to qualify for assistance under the Roadmap, the practice coach must demonstrate a commitment to and a plan for addressing the 11 core practice team functions in its coaching. The OHS-contracted third party(ies) will design a centralized coaching curriculum that all external coaches may adopt and use.

Regardless of the practice coaching vehicle, practice teams undergo an initial and then a periodic assessment to evaluate practice team functionality relative to the 11 core functions. Practice teams must demonstrate mastery of the core functions to the satisfaction of the OHS-contracted third party(ies).

2.4.2.2 Learning Collaborative(s)

Learning collaboratives can be an effective forum for peer-to-peer learning, including problem solving and sharing of best practices. OHS' Roadmap includes a voluntary learning collaborative that is offered to every practice seeking or that has obtained OHS practice team recognition (refer to Section 3.3 for the process to become "OHS-recognized"). Separate learning collaboratives are organized around care of children and adolescents and care of adults. The learning collaborative are provided by the same OHS-contracted third party(ies) as referenced above, contingent on state funding.

2.4.3 Methods to Assess and Recognize Practice Team Performance

Throughout the Roadmap development process, commercial insurers sought to better understand how primary care practices would use the increased primary care investments, as required by Executive Order No. 5. To address this concern, this Roadmap employs methods to assess and recognize core practice team core function adoption. Such practices will be deemed "OHS-recognized." The PCSG deliberated on several different options for practices to become OHS-recognized, including national recognition (i.e., NCQA's Patient-Centered Medical Home recognition program), state-developed recognition (i.e., OHS Advanced Medical Home Program and other like state-developed programs used in Minnesota and Oregon), practice self-attestation, and practice self-attestation with limited verification. The PCSG ultimately recommended to OHS, and OHS adopted, a hybrid option that includes a state-developed recognition program.

The recognition process includes two pathways for practices to become OHS-recognized:

1. **Practices currently recognized by NCQA as a PCMH, including all DSS PCMH+ recognized practices, qualify for recognition with some limited additional requirements.** Practice teams must:

- demonstrate embedded care management, care coordination and behavioral health functionality within two years;
- identify how additional investment (enhanced payments) will be allocated to support improved patient care; and
- work earnestly, and with commitment to quality improvement, with an OHS-recognized practice coach until demonstrating mastery of all 11 core practice team functions to OHS's satisfaction.

2. **Practices not recognized by NCQA or that were once recognized but let the recognition lapse, can seek recognition from OHS.** Practice teams must:

   - attest to and demonstrate mastery of the 11 OHS core practice team functions. Practice teams must demonstrate six functions at the outset, nine functions after one year, and all 11 functions after two years;
   - demonstrate embedded care management, care coordination and behavioral health functionality within two years;
   - identify how additional investment (enhanced payments) will be allocated to support improved patient care; and
   - work earnestly, and with commitment to quality improvement, with an OHS-recognized practice coach until demonstrating mastery of all 11 core practice team functions to OHS' satisfaction.

All OHS-recognized practice teams must renew their recognition every two years by taking the following actions:

- NCQA-recognized PCMH practice teams: demonstrating current NCQA PCMH recognition and continued embedded care management, care coordination and behavioral health functionality.
- OHS-recognized practice teams: attesting to and demonstrating mastery of the 11 OHS core practice team functions, including but not limited to demonstration of continued embedded care management, care coordination and behavioral health functionality.

2.4.4 Primary Care Payment Models

Feedback on primary care alternative payment models from the PCSG and provider stakeholders revealed mixed perspectives. OHS heard from some practices a desire to move away from FFS payments, especially after the financial hardships created for some by COVID-19. Other practices expressed concern with moving towards primary care alternative models such as prospective payment, fearing decreased revenue.

OHS believes that non-FFS payment models are more supportive of team-based care, but appreciates the uncertainty that payment model transition creates for some practices. For this reason, the Roadmap includes the provision of a voluntary payment model option that providers may select in addition to the existing FFS model.

While this Roadmap defines a new voluntary payment option in addition to the FFS status quo, it also leaves open the possibility of additional aligned primary care alternative payment models in which providers can qualify for assistance should primary care practices and payers reach agreement on participation in such models. For example, prospective payment may or may not be nested within broader primary care alternative payment models that incorporate services in addition to primary care, such as those involving Accountable Care Organizations.

2.4.4.1 Payment Model Parameters

OHS identifies below a common set of parameters that insurers must adopt for any primary care alternative payment model in order to maximize overall success for both providers and payers and ensure patients are not harmed by a transition to new payment models. These parameters include the following (which are further detailed in the sections that follow):

1. Any risk-adjusted payments should be based on age, gender and clinical complexity+
2. Prospective patient panel identification for practices+
3. Measures and monitoring practices to protect against stinting of care and undesired adverse impact+
4. Multi-payer alignment on contractual primary care quality measures that include equity-focused measures*
5. Practice eligibility for meaningful incentive payments based on quality performance*
6. Data sharing and education*

+These parameters apply only to the value-based prospective and primary care alternative payment models.
**These parameters apply to value-based prospective and primary care alternative payment models and to FFS payment models.*

1. Risk-adjusted payments based on age, gender and clinical complexity

Risk adjustment is intended to reflect the relative risk of the patient panel in primary care alternative payment models, reducing the incentive for a practice to seek out healthier patients and discourage sicker patients. It also recognizes the need for children to have high volumes of preventive care visits, especially when they are very young.

Parameter: Insurers risk adjust their payment models to account for variation in the health care conditions of different patient panels and for age and gender.

Insurers may implement the risk adjustment tool of their choice but should provide a high level of transparency to practices about how the software is applied, including underlying parameters, assumptions applied by the insurer, and the impact of risk adjustment on payments.

2. Prospective patient panel identification for practices

A primary care practice that contracts on any prospective payment basis is paid prospectively for those patients attributed to the practice. The practice receives a FFS payment for the care of other patients and for services other than the prospectively paid services delivered to the attributed patients.

Parameter: Insurers provide prospective notification of those patients for whom they are receiving capitated payment. Insurers can utilize a patient attribution methodology of their choosing, which may include attribution methodologies in current use, so long as they are transparent about the methodology with practices. Insurers reattribute patients monthly, communicate these updates to practices in a timely manner, and use these updates when calculating capitation payments.

3. Measures and monitoring practices to protect against stinting of care and undesired adverse impact

As with any payment model, prospective and other models have some potential limitations. For example, there is a risk that practices could take on more patients than they can realistically care for, resulting in limited appointment availability, or practices could direct patients to unnecessary utilization of specialist and emergency care.

Parameter: Insurers carefully monitor practice behavior to identify cases where access is decreasing or there are other signs of stinting on care. Insurers use available data to monitor for this potential problem and take corrective action when performance measures indicate the need to do so. To protect against this risk, insurers create incentives and/or disincentives for practices to minimize inappropriate use of specialists and emergency departments. Quality measures included in the payment models include measures of access and other member-reported measures of satisfaction.

4. Multi-payer alignment on contractual primary care quality measures

Quality measurement and related performance incentives are critical to improving patient care, outcomes, and experience. Quality measurement, reporting and improvement requirements can be burdensome on practices, particularly small practices that lack the infrastructure to effectively respond to divergent insurer quality requirements. A quality measurement strategy for primary care aligned across insurers, with manageable reporting requirements, helps minimize administrative burden on practices and improves the likelihood that practices will

Parameter: Insurers adopt for universal primary care contractual use an aligned set of quality measures that include equity-focused measures. OHS' Quality Council will define and maintain a subset of primary care measures, derived from OHS' Core Measure Set, that will serve this purpose.

focus on highest priority quality improvement opportunities and achieve improved performance for their patients.

5. **Practice eligibility for substantial incentive payments based on quality performance**

The primary care payment model meaningfully rewards quality with an opportunity to earn substantial incentive payments based on practices' performance on certain measures. Existing primary care payment in Connecticut includes a de minimis level of incentive payments to primary care practices.

Parameter: Insurers offer and make payment related to substantial quality incentives.

6. **Data sharing and education**

High quality data exchange is necessary for insurers and practices to effectively care for primary care patients. In addition, some practices will benefit from education and coaching about how to deliver patient care in a financially sustainable way in the context of a capitated payment methodology.

Parameter: Insurers supply providers with timely, high-quality data to allow more effective management of their patient panel and their revenue under a capitated arrangement. This includes data about a practice's panel, risk scores, and associated payment calculations. Insurers also provide appropriate technical assistance and educational support to facilitate the transition to capitated payments.

2.4.4.2 Payment Model Options

OHS makes available payment model options for practices, including a voluntary prospective payment model, FFS, and additional primary care alternative payment models so that practices interested in transitioning away from FFS with commercial payers can do so. The options are described below.

1. **Practices may voluntarily opt for a value-based prospective primary care payment model[11] that is made available by each of Connecticut's leading commercial insurers.** Interested primary care practices are prospectively paid a fixed monthly PMPM fee for most primary care services in lieu of FFS payments, regardless of the services provided to the practice's defined patient panel during a given month. Substantial quality incentive payments are made available as a complement to the prospective payment.
2. **Practices can choose to continue receiving FFS payments.** Substantial quality incentive payments are made available as a complement to the FFS payments**.**

[11] Prospective primary care payment is sometimes referred to as "capitation" because the prospective payment is made on a per patient basis.

3. **Insurers and practices can enter into other primary care alternative payment models that support and align with the model parameters described above.**

Practices are eligible for enhanced payments, as called for by the governor's primary care spend target, under these approaches, so long as they are seeking or have obtained OHS-recognition for mastery of the 11 primary care core practice team functions.

2.4.4.3 Benefits of a Prospective Payment Model

Prospective payment for primary care is the normative primary care payment model in some other states and regional markets. Primary care prospective payment in 2021 is far different than what it was when first tried decades ago.[12] Several leading national organizations now support use of prospective payment, in part or in full, as a model to sustain and improve our nation's vulnerable primary care foundation. Such organizations include the National Academy of Medicine,[13] CMS,[14] the Primary Care Collaborative[15] and the Milbank Memorial Fund.

In addition, several other states supporting primary care transformation and payment reform programs are including prospective payment. Rhode Island,[16] Colorado,[17] and Washington[18] are just three examples.

A prospective payment model can offer the following benefits to primary care practices:

- greater flexibility to deliver primary care that better meets the needs and preferences of patients (e.g., traditionally uncompensated time to coordinate care for medical and social needs outside of the practice);
- maximization of team-based services using care modalities (e.g., email, telephone calls) and care team members (e.g., community health workers) that/who aren't often compensated under traditional FFS models;
- removal of the financial imperative to generate office visits to generate income;
- predictable monthly cash flow (COVID-19 has revealed how important this can be); and
- limited financial risk to the practice because the payment only includes those services the practice team delivers.

Prospective payment can also support patient interests. Patients benefit in the following ways:

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[12] https://www.milbank.org/publications/prospective-payment-for-primary-care-lessons-for-future-models/

[13] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

[14] https://innovation.cms.gov/innovation-models/primary-care-first-model-options

[15] https://www.pcpcc.org/topic-page/payment-reform

[16] https://www.milbank.org/news/rhode-islands-updated-affordability-standards-to-support-behavioral-health-and-alternative-payment-models/

[17] https://drive.google.com/file/d/1Ug-npJYAqZk0R4A2IMTsKWm1uQYucMnk/view

[18] https://www.hca.wa.gov/assets/WA-PC-model-for-Public-Comment-7-13-2020.pdf

- financial flexibility for an expanded care team that is more equipped to provide a whole-person care approach to address a patient's physical, mental, and social needs, including use of community health workers, pharmacists, etc.;
- different care modalities provide the convenience of various types of appointments and increase access to the practice;
- practices can allocate more time and attention for individual patients most in need of it; and
- practices don't need to require patients to come in for unnecessary and inconvenient office visits when a telephone call or email communication suffices to meet a patient's need.

For those practices and payers considering a more gradual transition to full prospective payment, OHS will work with DSS, other payers, providers, and stakeholders to develop payment models that support the key primary care functions and parameters of primary care as outlined in the roadmap.

3 Structural Barriers to High-Quality Primary Care

The purpose of the Roadmap development process was to design a care delivery and payment model to bolster primary care in CT. It was not meant, nor would it be possible, to address all current challenges to the primary care delivery system. However, the process highlighted many barriers to high-quality primary care that are important to raise in this document to elevate understanding and visibility across a broader audience. OHS identifies below in Table 3 identified barriers and current or planned action underway that may help address them.

Table 3: Barriers to high-quality primary care with current or planned actions

Barrier	Description	Current or Planned Action
Current Primary Care Payment Model(s)	PCSG members and stakeholders consistently identified current fee-for-service (FFS) payment system as a major barrier to achieving high-quality primary care. Some cited examples include: a) inadequate payment for comprehensive care or the time spent by practices outside of direct care; b) inflexible definitions of who can deliver services and bill for them; c) inability to support upfront staff training or coordination with social service providers; d) lack of use of expanded care teams because members are not currently paid under FFS payment models;	▪ Executive Order No. 5 implementation, including increasing primary care spending (a). ▪ OHS Roadmap payment model options and related aligned payment parameters, including enhanced payments, substantial incentive payments based on quality performance, and multi-payer alignment on primary care quality measures (a, b, c, e, f). ▪ OHS Roadmap voluntary prospective

Barrier	Description	Current or Planned Action
	e) inability to support innovations in care, such as group visits, home visiting, extended health education sessions, and telephone and other virtual consults directly with patients; f) misaligned payment models across payers; and g) funding for community health worker (CHW) development.	payment model coupled with increased payment levels to support core practice team functions that support expanded care teams, including non-clinical care coordination personnel to connect patients with community supports to address social risk factors (d). ▪ OHS collaboration with the Community Health Worker Association of Connecticut (CHWACT) to become a freestanding organization by 2023 through funding from the CDC. CHWACT will provide information, training, and capacity building for CHWs, employers, champions, and community members while also providing networking and professional development opportunities (g). ▪ OHS collaboration with the Governor's Office and executive agencies on strategy, program design, and current training opportunities and gaps for CHWs (g).
Access	Many of the barriers relating to access to primary care heard by OHS were specific to technology, workforce needs, and payment which are addressed separately. However, OHS also heard of barriers to primary care that are influenced by social determinants of health (SDOH). Some	▪ OHS collaboration with other state agencies on "food as health initiatives." ▪ Efforts of OHS' Community Health Subgroup and Health Enhancement

Barrier	Description	Current or Planned Action
	cited examples included transportation and food and pharmacy deserts.	Communities to address SDOH at the community-level.
Administrative Requirements	OHS' Roadmap payment model option for voluntary prospective payment will reduce some administrative requirements on primary care practices; however, it will not solve for other administrative burdens on primary care practices that practices argue present a major barrier to high-quality primary care: ▪ a high volume of paperwork and reporting requirements, including paperwork that only a physician can sign; ▪ electronic medical record "checklist" documentation; ▪ payer-required pre-authorizations and coding requirements; and ▪ chart review requirements.	▪ OHS collaboration with other state agencies and stakeholders to assess policies and strategies to help reduce identified administrative barriers.
Technology	OHS heard that technology-related barriers continue to be an issue for primary care practices and patients, including: a) lack of technology for telehealth; b) lack of broadband access across the continuum of care; c) lack of access to all patient information; and d) needed enhancements in IT infrastructure for primary care and other organizations that support primary care such as community-based organizations.	▪ OHS planned collaboration with its Health Information Technology Office and Health IT Advisory Council (a, d). ▪ Work currently underway by state agencies to implement Public Act 21-159 – An Act Concerning Equitable Access to Broadband (b). ▪ the statewide health information exchange "Connie" (c).
Primary Care Workforce	Highlighted consistently throughout the Roadmap development process were concerns around CT's primary care workforce. Some cited examples include: a) rate of burnout among primary care professionals and lifestyle considerations;	▪ OHS collaboration with other state agencies and the Governor's Office of Workforce Strategy to address primary care workforce deficiencies (c, d, e, f, g).

Barrier	Description	Current or Planned Action
	b) market competition (hospitals hire away from practices because they can offer higher pay); c) inadequate supply of PCPs; d) underutilization of highly trained clinicians as expanded care team members; e) lack of primary care practice team working knowledge of special populations; f) increased referrals by PCPs to specialists for primary care due to lack of training; g) inadequate training for advanced practice providers (APPs); and h) lack of behavioral health and substance use specialists to support primary care.	▪ OHS Roadmap core practice team functions that support use of expanded care teams and voluntary prospective payment model (a, b). ▪ Department of Public Health funding for loan forgiveness for primary care providers (c). ▪ OHS Physician Practice Workgroup established through Public Act No. 21-129 to study (1) methods to improve oversight and regulation of mergers and acquisitions of physician practices and (2) methods to ensure the viability of physician practices (b). ▪ OHS collaboration with other state agencies to support primary care and behavioral health integration (h).

4 Roadmap Implementation Plan

The implementation plan describes who is responsible for what actions and by when to successfully implement the Roadmap. Implementation activities are planned to start sometime in 2022.

The primary actors responsible for implementing the Roadmap include OHS, DSS, commercial insurers, and primary care practice teams. Implementation activities for years one (2022) and two (2023) are presented in the Tables 5 and 6 below.

Table 4: Year One Implementation Activities

Year One Implementation Activities (2022)
OHS Implementation Activities
1. Obtain commitment from payers to achieving the primary care spend target and to the Roadmap. 2. Develop recommendations for how practices should invest additional primary care payments. 3. Develop Roadmap operational details, including: • interpretive guidance for core practice team functions so that practices know what is expected of them and OHS' contracted third party(ies) can objectively assess core practice team function mastery, • final implementation parameters for the primary care payment model, and • insurer and practice reporting requirements. 4. With advice from OHS' Quality Council, define a subset of primary care measures, derived from OHS' Core Measure Set, that insurers will use in all primary care practice value-based contracts. 5. Develop and release an RFP for an OHS-contracted third party(ies) to implement the OHS primary care program and contract for services. 6. With an OHS-contracted third party(ies), design the following processes: • practice application process, practice initial assessment, practice coaching central curriculum for all practice coaching sources, practice recognition process, practice biennial evaluation for continued recognition, learning collaborative(s) curriculum 7. Develop and implement a communications strategy for OHS' primary care program. 8. Assess any policy (or other) barriers to achieving Roadmap objectives and determine actions required. 9. Design a Roadmap monitoring and evaluation plan to assess each element of the Roadmap: • How will OHS know if it is succeeding along the way (process measures)? • How will OHS know if it succeeded (outcome measures)?
Commercial Insurer Implementation Activities
1. Commit to increasing primary care payment up to the target and to supporting Roadmap implementation and take necessary follow-up steps. 2. Ensure that quality incentive opportunities are substantial. 3. Prepare systems to administer *voluntary* primary care alternative payment models.
Practice Team Implementation Activities
1. Commit to directing practice resources properly to ensure increased primary care investments support Roadmap strategies and result in improved care and outcomes. 2. Participate in educational activities regarding the OHS primary care program.

Table 5: Year Two Implementation Activities

Year Two Implementation Activities (2023)
OHS Implementation Activities
1. Implement the primary care program. 2. Begin accepting practice applications to become OHS-recognized. 3. Begin Roadmap monitoring and evaluation. 4. Engage with insurance carriers through reporting activities to ensure primary care commitments are followed through. 5. Engage with primary care practices through reporting activities to capture progress and practice experiences with the OHS primary care program.
Commercial Insurer Implementation Activities
1. Participate in OHS primary care program. 2. Report to OHS on primary care commitments.
Practice Team Implementation Activities
1. Apply and participate in OHS primary care program to become OHS-recognized. 2. Report to OHS on progress and practice experiences with OHS' primary care program.

5 Primary Care Workforce Development

Critical to the implementation and success of the Roadmap is the primary care workforce. OHS heard consistently throughout the Roadmap development process from many stakeholders the importance of addressing CT's primary care workforce needs. Some key barriers are cited in Section 3, Structural Barriers to High-Quality Primary Care. While this Roadmap does not present a primary care workforce strategy, OHS will continue to work separately with Governor Lamont's Office of Workforce Strategy and other state agencies to address this important topic.

6 Conclusion

OHS deeply appreciates PCSG members for their time, commitment and recommendations towards a strengthened and sustained primary care system in CT, and to the many stakeholders that took the time to engage with OHS throughout the Roadmap development process to provide feedback.

The Roadmap, once implemented, is one of several critical strategies to address the state's primary care infrastructure. OHS will proceed with implementation activities in 2022 as outlined in this document and looks forward to continued engagement with stakeholders throughout the implementation process.

Appendix A: OHS' Definition of Primary Care Spending

A. Current Definition

Primary Care: The total medical expense (TME) paid to primary care providers (i.e., family medicine, general practice, geriatric, internal medicine and pediatric providers identified using taxonomy codes in Section B) as well as certain provider organization taxonomy codes (i.e., critical access hospitals, federally qualified health centers, rural hospitals and school-based health centers identified using taxonomy codes in Section B) generated from claims using the code-level definition found in Section C.

Primary Care (for Monitoring Purposes): The TME paid to primary care providers and certain provider organization taxonomy codes, as defined above and in Section B, as well as OB/GYNs and midwifery generated from claims using the code-level definition found in Section C.
For both definitions of primary care, insurance carriers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the carrier does not utilize the provider taxonomy codes in the file above, it may apply its provider codes to match the description of the provider taxonomy codes included.

B. Primary Care Specialties Provider Taxonomy Codes

The following table includes select provider taxonomy codes for the primary care specialties included in CT OHS' definition of primary care providers and certain provider organization taxonomy codes. The taxonomy codes included in this table are informed by the New England States Consortium Systems Organization' (NESCSO) 2020 definition of primary care spending.

Taxonomy	Description	Definition
208D00000X	General Practice	Primary and Monitoring
207Q00000X	Family Medicine	Primary and Monitoring
207QA0000X	Family Medicine, Adolescent Medicine	Primary and Monitoring
207QA0505X	Family Medicine, Adult Medicine	Primary and Monitoring
207QG0300X	Family Medicine, Geriatric Medicine	Primary and Monitoring
207QH0002X	Family Medicine, Hospice Palliative	Primary and Monitoring
208000000X	Pediatrics	Primary and Monitoring
2080A0000X	Pediatrics, Adolescent Medicine	Primary and Monitoring
2080H0002X	Pediatrics, Hospice and Palliative Medicine	Primary and Monitoring
207R00000X	Internal Medicine	Primary and Monitoring
207RG0300X	Internal Medicine, Geriatric Medicine	Primary and Monitoring
207RA0000X	Internal Medicine, Adolescent Medicine	Primary and Monitoring

Taxonomy	Description	Definition
207RH0002X	Internal Medicine, Hospice and Palliative Medicine	Primary and Monitoring
363A00000X	Physician Assistant	Primary and Monitoring
363AM0700X	Physician Assistant, Medical	Primary and Monitoring
363L00000X	Nurse Practitioner	Primary and Monitoring
363LA2200X	Nurse Practitioner, Adult Health	Primary and Monitoring
363LF0000X	Nurse Practitioner, Family	Primary and Monitoring
363LG0600X	Nurse Practitioner, Gerontology	Primary and Monitoring
363LP0200X	Nurse Practitioner, Pediatrics	Primary and Monitoring
363LP2300X	Nurse Practitioner, Primary Care	Primary and Monitoring
363LC1500X	Nurse Practitioner, Community Health	Primary and Monitoring
363LS0200X	Nurse Practitioner, School	Primary and Monitoring
261QF0400X	Federally Qualified Health Center (FQHC)	Primary and Monitoring
261QR1300X	Clinic/Center, Rural Health	Primary and Monitoring
261QP2300X	Clinic/Center, Primary Care	Primary and Monitoring
282NR1301X	Rural Hospital	Primary and Monitoring
261QC0050X	Critical Access Hospital	Primary and Monitoring
282NC0060X	Critical Access Hospital	Primary and Monitoring
363LX0001X	Nurse Practitioner, Obstetrics & Gynecology	Monitoring Only
363LW0102X	Nurse Practitioner, Women's Health	Monitoring Only
207V00000X	Obstetrics & Gynecology	Monitoring Only
207VG0400X	Obstetrics & Gynecology, Gynecology	Monitoring Only
176B00000X	Midwife	Monitoring Only
367A00000X	Midwife, Certified Nurse	Monitoring Only

C. Primary Care Payment Codes

The following table includes select procedure codes to identify primary care spending. The procedure codes included in this table are informed by the New England States Consortium Systems Organization' (NESCSO) 2020 definition of primary care spending. There were three CT-specific codes added to the NESCSO definition – two focused on preventive dental services (i.e., 99188 and 99429) and one focused on home visits for newborns (i.e., 99502).

Procedure Code	Description	Reporting Procedure Category
90460	IM ADM THRU 18YR ANY RTE 1ST/ONLY COMPT VAC/TOX	Immunization Administration for Vaccines/Toxoids
90461	IM ADM THRU 18YR ANY RTE ADDL VAC/TOX COMPT	Immunization Administration for Vaccines/Toxoids
90471	IM ADM PRQ ID SUBQ/IM NJXS 1 VACCINE	Immunization Administration for Vaccines/Toxoids
90472	IM ADM PRQ ID SUBQ/IM NJXS EA VACCINE	Immunization Administration for Vaccines/Toxoids
90473	IM ADM INTRANSL/ORAL 1 VACCINE	Immunization Administration for Vaccines/Toxoids
90474	IM ADM INTRANSL/ORAL EA VACCINE	Immunization Administration for Vaccines/Toxoids
96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counselings
96161	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counselings
98966	NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN	Telephone and Internet Services
98967	NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN	Telephone and Internet Services
98968	NONPHYSICIAN TELEPHONE ASSESSMENT 21-30 MIN	Telephone and Internet Services
98969	NONPHYSICIAN ONLINE ASSESSMENT AND MANAGEMENT	Telephone and Internet Services
99078	PHYS/QHP EDUCATION SVCS RENDERED PTS GRP SETTING	Health Risk Assessment, Screenings, and Counselings
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT	Preventive Medicine Services
99188	APPLICATION OF TOPICAL FLUORIDE VARNISH BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	Preventive Dental Services
99201	OFFICE OUTPATIENT NEW 10 MINUTES	Office Visits
99202	OFFICE OUTPATIENT NEW 20 MINUTES	Office Visits
99203	OFFICE OUTPATIENT NEW 30 MINUTES	Office Visits
99204	OFFICE OUTPATIENT NEW 45 MINUTES	Office Visits
99205	OFFICE OUTPATIENT NEW 60 MINUTES	Office Visits
99211	OFFICE OUTPATIENT VISIT 5 MINUTES	Office Visits
99212	OFFICE OUTPATIENT VISIT 10 MINUTES	Office Visits
99213	OFFICE OUTPATIENT VISIT 15 MINUTES	Office Visits
99214	OFFICE OUTPATIENT VISIT 25 MINUTES	Office Visits
99215	OFFICE OUTPATIENT VISIT 40 MINUTES	Office Visits

Procedure Code	Description	Reporting Procedure Category
99241	OFFICE CONSULTATION NEW/ESTAB PATIENT 15 MIN	Consultation Services
99242	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN	Consultation Services
99243	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN	Consultation Services
99244	OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN	Consultation Services
99245	OFFICE CONSULTATION NEW/ESTAB PATIENT LEVEL 5	Consultation Services
99339	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 15-29 MIN	Domiciliary, Rest Home Multidisciplinary Care Planning
99340	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 30 MIN/>	Domiciliary, Rest Home Multidisciplinary Care Planning
99341	HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES	Home Visits
99342	HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES	Home Visits
99343	HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES	Home Visits
99344	HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES	Home Visits
99345	HOME VISIT NEW PT UNSTABL/SIGNIF NEW PROB 75 MIN	Home Visits
99347	HOME VISIT EST PT SELF LIMITED/MINOR 15 MINUTES	Home Visits
99348	HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES	Home Visits
99349	HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES	Home Visits
99350	HOME VST EST PT UNSTABLE/SIGNIF NEW PROB 60 MINS	Home Visits
99358	PROLNG E/M SVC BEFORE&/AFTER DIR PT CARE 1ST HR	Prolonged Services
99359	PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES	Prolonged Services
99360	PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES	Prolonged Services
99366	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN	Case Management Services
99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN	Case Management Services

Procedure Code	Description	Reporting Procedure Category
99368	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN	Case Management Services
99374	SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES	Hospice/Home Health Services
99375	SUPERVISION PT HOME HEALTH AGENCY MONTH 30 MIN/>	Hospice/Home Health Services
99376	CARE PLAN OVERSIGHT/OVER	Hospice/Home Health Services
99377	SUPERVISION HOSPICE PATIENT/MONTH 15-29 MIN	Hospice/Home Health Services
99378	SUPERVISION HOSPICE PATIENT/MONTH 30 MINUTES/>	Hospice/Home Health Services
99381	INITIAL PREVENTIVE MEDICINE NEW PATIENT <1YEAR	Preventive Medicine Visits
99382	INITIAL PREVENTIVE MEDICINE NEW PT AGE 1-4 YRS	Preventive Medicine Visits
99383	INITIAL PREVENTIVE MEDICINE NEW PT AGE 5-11 YRS	Preventive Medicine Visits
99384	INITIAL PREVENTIVE MEDICINE NEW PT AGE 12-17 YR	Preventive Medicine Visits
99385	INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS	Preventive Medicine Visits
99386	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS	Preventive Medicine Visits
99387	INITIAL PREVENTIVE MEDICINE NEW PATIENT 65YRS&>	Preventive Medicine Visits
99391	PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y	Preventive Medicine Visits
99392	PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS	Preventive Medicine Visits
99393	PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS	Preventive Medicine Visits
99394	PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS	Preventive Medicine Visits
99395	PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS	Preventive Medicine Visits
99396	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS	Preventive Medicine Visits
99397	PERIODIC PREVENTIVE MED EST PATIENT 65YRS& OLDER	Preventive Medicine Visits
99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN	Preventive Medicine Services
99402	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 30 MIN	Preventive Medicine Services

Procedure Code	Description	Reporting Procedure Category
99403	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 45 MIN	Preventive Medicine Services
99404	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 60 MIN	Preventive Medicine Services
99406	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	Preventive Medicine Services
99407	TOBACCO USE CESSATION INTENSIVE >10 MINUTES	Preventive Medicine Services
99408	ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN	Preventive Medicine Services
99409	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN	Preventive Medicine Services
99411	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 30 M	Preventive Medicine Services
99412	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 60 M	Preventive Medicine Services
99420	ADMN & INTERPJ HEALTH RISK ASSESSMENT INSTRUMENT	Preventive Medicine Services
99429	UNLISTED PREVENTIVE MEDICINE SERVICE	Preventive Medicine Services/Preventive Dental Care
99441	PHYS/QHP TELEPHONE EVALUATION 5-10 MIN	Telephone and Internet Services
99442	PHYS/QHP TELEPHONE EVALUATION 11-20 MIN	Telephone and Internet Services
99443	PHYS/QHP TELEPHONE EVALUATION 21-30 MIN	Telephone and Internet Services
99444	PHYS/QHP ONLINE EVALUATION & MANAGEMENT SERVICE	Telephone and Internet Services
99446	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5-10 MIN	Telephone and Internet Services
99447	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 11-20 MIN	Telephone and Internet Services
99448	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 21-30 MIN	Telephone and Internet Services
99449	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 31/> MIN	Telephone and Internet Services
99451	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5/> MIN	Telephone and Internet Services
99452	NTRPROF PHONE/NTRNET/EHR REFERRAL SVC 30 MIN	Telephone and Internet Services
99483	ASSMT & CARE PLANNING PT W/COGNITIVE IMPAIRMENT	Health Risk Assessment, Screenings, and Counselings

Procedure Code	Description	Reporting Procedure Category
99487	CMPLX CHRON CARE MGMT W/O PT VST 1ST HR PER MO	Chronic Care Management Services
99489	CMPLX CHRON CARE MGMT EA ADDL 30 MIN PER MONTH	Chronic Care Management Services
99490	CHRON CARE MANAGEMENT SRVC 20 MIN PER MONTH	Chronic Care Management Services
99491	CHRON CARE MANAGEMENT SRVC 30 MIN PER MONTH	Chronic Care Management Services
99495	TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE	Transitional Care Management Services
99496	TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE	Transitional Care Management Services
99497	ADVANCE CARE PLANNING FIRST 30 MINS	Advance Care Planning Evaluation & Management Services
99498	ADVANCE CARE PLANNING EA ADDL 30 MINS	Advance Care Planning Evaluation & Management Services
99499	UNLISTED EVALUTION AND MANAGEMENT SERVICE	Preventive Medicine Services/Preventive Dental Care
99502	HOME VISIT FOR NEWBORN CARE AND ASSESSMENT	Home Visits for Newborns
G0008	ADMINISTRATION OF INFLUENZA VIRUS VACCINE	Immunization Administration for Vaccines/Toxoids
G0009	ADMINISTRATION OF PNEUMOCOCCAL VACCINE	Immunization Administration for Vaccines/Toxoids
G0010	ADMINISTRATION OF HEPATITIS B VACCINE	Immunization Administration for Vaccines/Toxoids
G0102	PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION	Preventive Medicine Services
G0179	PHYS RE-CERT MCR-COVR HOM HLTH SRVC RE-CERT PRD	Hospice/Home Health Services
G0180	PHYS CERT MCR-COVR HOM HLTH SRVC PER CERT PRD	Hospice/Home Health Services
G0181	PHYS SUPV PT RECV MCR-COVR SRVC HOM HLTH AGCY	Hospice/Home Health Services
G0182	PHYS SUPV PT UNDER MEDICARE-APPROVED HOSPICE	Hospice/Home Health Services
G0396	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN	Health Risk Assessment, Screenings, and Counselings
G0397	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN	Health Risk Assessment, Screenings, and Counselings

Procedure Code	Description	Reporting Procedure Category
G0402	INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR	HCPC Visit Codes
G0436	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN	Preventive Medicine Services
G0437	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN	Preventive Medicine Services
G0438	ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT	HCPC Visit Codes
G0439	ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQT VST	HCPC Visit Codes
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counselings
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN	Health Risk Assessment, Screenings, and Counselings
G0444	ANNUAL DEPRESSION SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counselings
G0463	HOSPITAL OUTPATIENT CLIN VISIT ASSESS & MGMT PT	HCPC Visit Codes
G0466	FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT	HCPC Visit Codes
G0467	FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT	HCPC Visit Codes
G0468	FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/AWV	HCPC Visit Codes
G0505	COGN & FUNCT ASMT USING STD INST OFF/OTH OP/HOME	Health Risk Assessment, Screenings, and Counselings
G0506	COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC	Chronic Care Management Services
G0513	PRLNG PREV SRVC OFC/OTH O/P RQR DIR CTC;1ST 30 M	Prolonged Services
G0514	PRLNG PREV SRVC OFC/OTH O/P DIR CTC;EA ADD 30 M	Prolonged Services
S9117	BACK SCHOOL VISIT	HCPC Visit Codes
T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE	HCPC Visit Codes
11982	Removal, non- biodegradable drug delivery implant	Contraceptive Insertion/Removal
58301	Removal of IUD	Contraceptive Insertion/Removal
11981	Insertion, non- biodegradable drug delivery implant	Contraceptive Insertion/Removal
11983	Removal with reinsertion, non- biodegradable drug delivery implant	Contraceptive Insertion/Removal

Procedure Code	Description	Reporting Procedure Category
57170	Diaphragm or cervical cap fitting with instructions	Contraceptive Insertion/Removal
58300	Insertion of IUD	Contraceptive Insertion/Removal
G0101	CERV/VAGINAL CANCER SCR; PELV&CLIN BREAST EXAM	Gynecological Services
Q0091	SCREEN PAP SMEAR; OBTAIN PREP &C ONVEY TO LAB	Gynecological Services
S0610	ANNUAL GYNECOLOGICAL EXAM, ESTABLISHED PATIENT	Gynecological Services
S0612	ANNUAL GYNECOLOGICAL EXAM, NEW PATIENT	Gynecological Services
S0613	ANNUAL GYNECOLOGICAL EXAM, BREAST EXAM W/O PELVIC	Gynecological Services
S4981	Insertion of levonorgestrel- releasing intrauterine system	Contraceptive Insertion/Removal

Appendix B: OHS Primary Care Initiative and Medicaid Comparison

A. Primary Care Concepts

DSS PCMH+ concepts	OHS core practice team functions
Team-Based Care and Practice Organization: Helps structure a practice's leadership, care team responsibilities and how the practice partners with patients, families, and caregivers.	Care delivery is centered around what matters to the patient, developing **trusted relationship with patients,** making them feel heard and listened to, and instilling person-centered practices from the front desk to post-visit follow up.
	Care delivery is **team-based,** with the practice team consisting of a range of clinicians and non-clinicians, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials**.**
	Practice teams formally designate a **lead clinician** for each patient. That person fosters a continuous, longitudinal relationship.
	Practices deliver "**planned care**" at every visit, including reviewing the patient's medical record prior to the visit and addressing all identified issues during the visit.
Care Coordination and Care Transitions: Ensures that primary and specialty care clinicians are effectively sharing information and managing patient referrals to minimize cost, confusion and inappropriate care. **Care Management and Support**: Helps clinicians set up care management protocols to identify patients who need more closely managed care.	Practice teams **coordinate care** for its patients between visits and across the continuum of care. To support such work, the practice team includes: **(a) qualified embedded clinical care management personnel** to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and (b) **embedded non-clinical care coordination personnel** to connect all patients with community supports to address social risk factors, and work with families and other caregivers.
Promote linkages to community supports that can assist members in maximizing their Medicaid benefits.	The practice teams identify **social risk factors** affecting its patients and is knowledgeable about **community resources** that can address social needs.

DSS PCMH+ concepts	OHS core practice team functions
Build on provider competencies to support members with complex medical conditions and disabilities.	
Integration of physical and behavioral health care.	**Behavioral health** is integrated into the practice through (a) mental health clinicians who are members of the practice and provide assessment, brief treatment, and referral, and (b) through screening and referral for substance use treatment.
Patient-Centered Access and Continuity: Guides practices to provide patients with convenient access to clinical advice and helps ensure continuity of care.	Care is **easily accessible,** and prompt using multiple care modalities, including in-person, electronic, and virtual visits, and including time outside of traditional work hours. Care is accessible to persons with disabilities and is culturally and linguistically competent.
Knowing and Managing Your Patients: Sets standards for data collection, medication reconciliation, evidence-based clinical decision support, and other activities.	Care delivery follows **evidence-based** guidelines for prevention, health promotion, and chronic illness care, supported by EHR clinical decision support.
Promote overall health and wellness for members.	Practices **engage and support patients** in healthy living and in management of chronic conditions.
Performance Measurement and Quality Improvement: Improvement helps practices develop ways to measure performance, set goals, and develop activities that will improve performance.	The practice team **utilizes patient information in conjunction with data from an EHR when utilized by the practice, HIE, pharmacies, and payers** to identify patient care needs, monitor change over time, and inform **quality and equity improvement** activity, including design and implementation of quality improvement plans.

B. Primary Care Practice Team Supports, Recognition, and Payment

	Medicaid PCMH+	OHS Primary Care
Practice Supports		
	❑ Learning Collaborative ❑ Practice Coaching	❑ Learning Collaborative ❑ Practice Coaching
Practice Recognition		
	❑ NCQA recognition	❑ All CT primary care practices currently recognized by NCQA, including DSS PCMH+ recognized practices ❑ State developed recognition process for practices seeking OHS recognition
Practice Payment		
	❑ Fee-for-service ❑ Monthly prospective care coordination payments ❑ Opportunities for shared savings based on quality performance	❑ Fee-for-service ❑ Voluntary prospective payment model ❑ Additional models that are of interest to practices and payers and supportive of primary care

Appendix C: OHS Primary Care Subgroup Membership

Name	Affiliation
Lesley Bennett	Consumer Representative
Rowena Bergmans	Nuvance Health
Seth Clohosey	Trinity
Stephanie de Abreu	United Healthcare
Mario Garcia	CT Department of Public Health
Heather Gates	Community Health Resources
Alex Geertsma	CT Chapter American Academy of Pediatrics
Shirley Girouard	Consumer Representative
April Greene	Aetna
Karen Hlavac	Council on Developmental Services
Lisa Honigfeld	Consumer Representative
Ken Lalime	Community Health Center Association of Connecticut (CHCACT)
Leslie Miller	Leslie Miller PC
Naomi Nomizu	Hartford Healthcare
Lori Pennito/Michele Wolfsberg	Harvard Pilgrim/Tufts Health Plan
Hugh Penny	Yale
Brad Richards	CT Department of Social Services
Theresa Riordan	Anthem
Dashni Sathasivam	Health Equity Solutions
Marie Smith	UConn School of Pharmacy
Rachel Southard	Starling Physicians
Elsa Stone	CT Chap. American Academy of Pediatrics
Randy Trowbridge	Team Rehab
Lisa Trumble	SOHO Health
Tom Woodruff	Office of the State Comptroller

Appendix D: Summary of Feedback from Public Comment Period (placeholder)