Primary Care Subgroup Meeting
July 27, 2021

Meeting Date	Meeting Time	Location
July 27, 2021	1:00 pm – 3:00 pm	Webinar/Zoom

Participant Name and Attendance

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

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**
	Hanna Nagy called the meeting to order at 1:12PM. Hanna Nagy administered the roll call and introduced new Subgroup member Dashni Sathasivam, affiliated with Health Equity Solutions.	
2.	**Public Comment**	**Hanna Nagy**
	Hanna Nagy invited public comment. None was voiced.	
3.	**Approval of the June 22nd Meeting Minutes**	**Hanna Nagy**
	Karen Hlavac moved to approve the minutes from the June 22nd meeting and Shirley Girouard seconded. Dashni Sathasivam abstained from approving the meeting minutes. The minutes were approved.	
4.	**June Subgroup Meeting Recap**	**Erin Campbell**
	Erin Campbell recapped the decisions and discussion from the June 22nd Subgroup meeting. Erin shared that final edits were made to the 11 core practice team functions based on Subgroup and stakeholder feedback. Erin reminded the Subgroup that at the June 22nd meeting the Subgroup continued discussing practice team supports and options for confirming practice adoption of core practice team functions. Erin summarized feedback from the Subgroup on these topics during the June 22nd meeting. **Discussion:** • Shirley Girouard asked about the status of the Subgroup's primary care definition. Erin said the revised primary care definition was circulated to the Subgroup with the meeting materials. Shirley said she would not feel comfortable approving core functions until the definition of primary care was finalized. Lesley Bennett and Marie Smith echoed Shirley's concerns. Erin clarified the core functions were not final and would not be considered final until the Subgroup reaches consensus. • Kelly Sinko said the Subgroup would not move forward with confirming the primary care definition or the core functions until all feedback from the Subgroup was processed. Michael Bailit clarified that the core functions being defined by the Subgroup had no impact on DSS' PCMH+ recognition program. Brad Richards confirmed this was true.	

DRAFT

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5.	Continuation of Roadmap Development	Erin Campbell / Michael Bailit

Practice Team Coaching and Learning Collaborative Proposals

Erin Campbell presented revised proposals for practice team supports and the learning collaborative, explaining that the modifications were informed by Subgroup feedback:

1. *Practice coaches are primarily provided by an OHS-contracted third party*
    a. *Practice teams seeking enhanced payments are required to work with a practice coach*
    b. *Some practice teams may receive coaching by a commercial insurer*
    c. *The third party is funded by large commercial carriers on a pro rata basis*
2. *A learning collaborative is provided by an OHS-contracted third party*
    a. *Participation is voluntary and offered to all practices seeking or that have already obtained OHS recognition*
    b. *The learning collaborative is contingent on state funding*

Erin asked for feedback from the Subgroup on the practice team coaching and learning collaborative proposals.

Discussion:

- Shirley Girouard (in the chat) disagreed with the sequence of the Subgroup meeting and reiterated that the primary care definition should be established before the Subgroup confirms the core functions.
- Alex Geertsma asked how practices would be assessed and advised against self-reporting. Erin said the Subgroup would address assessment and recognition of core function mastery later in the meeting.
- Shirley Girouard said that not every primary care practice needs a coach to meet the core criteria and practices should be allowed to collaborate with external supports and still demonstrate mastery of core practice functions. Michael Bailit agreed that some degree of flexibility should be allowed.
- Shirley Girouard expressed concern about the cost of practice coaches and how they would be financed. Erin clarified that the funding would be shared across commercial insurers. Michael asked Shirley what her preference would be for funding. Shirley suggested a grant rather than funding by taxpayer dollars or insurance premiums, and leveraging expertise from academic partners. Michael said foundations do not tend to fund this type of function and said there are three main options for funding: practices, payers, or taxpayers.
- April Greene asked about the intersection of the proposal with existing value-based arrangements and said the costs would be passed on to employers. Theresa Riordan echoed April Greene's comments and said payers would need more details about the structure and details of the proposal before they could assess the relationship of the proposal to existing insurer value-based arrangements.
- Alex Geertsma said that although there should be flexibility in practice coaching, there should also be uniformity on an agreed upon curriculum.
- Brad Richards supported the comments regarding value-based contracting, suggesting that insurers are currently engaging primary care practices in different ways, although not necessarily always in the form of practice coaching to support mastery of advanced primary care functions.
- Elsa Stone asked whether there would be an expectation of uniformity by insurers. Erin agreed uniformity would be necessary.
- Leslie Miller asked which practices the proposals were designed to serve, given many independent practices have joined hospitals or "gone concierge." Michael Bailit said the intent was to create options that would be applicable to both independent and hospital-based practices. Leslie Miller said the payment system should support practices and not make it more costly or administratively

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burdensome for practices to care for patients. Michael reminded the Subgroup that the Governor's Executive Order called for doubling investment in primary care.

- Randy Trowbridge said the Subgroup should agree on the importance of centering patient needs and doubling the investment in practice care was a good starting point. Michael said disagreements among Subgroup members were inevitable. Shirley Girouard agreed that Subgroup members share an investment in patient needs. Leslie Miller said she had deep concerns about patient protection.
- Brad Richards said payment reform is a critical component of defining primary care and establishing core functions.
- Marie Smith (in the chat) noted that doubling money for primary care in Connecticut would lead to investment in better patient outcomes and better provider/team satisfaction.
- Michael summarized what he had heard at this point from the Subgroup:
    - The Subgroup recommended allowing practices to use their own practice coach resources when they had such resources.
    - The Subgroup requested an additional review and discussion of the practice team core functions.
    - Insurers requested consideration of practice coaching in the context of existing value-based arrangements after the proposal was further defined.
- Michael invited Subgroup members to share feedback on the practice coaching and the learning collaborative proposals.
- Karen Hlavac said practices need coaching on very specific populations (e.g., patients with intellectual and developmental disabilities). Michael agreed and shared that DSS raised similar feedback, and that OHS was considering a modification to the core functions. Michael added that practice coaches could be trained on this skill and the learning collaborative curriculum could be delivered by subject matter experts.

Practice Team Recognition Program Proposal

Erin Campbell shared a draft practice team recognition program proposal for group consideration:

- *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.*
    2. *Practices not recognized by NCQA, or that were NCQA-recognized but let the recognition relapse, can seek recognition from OHS.*
- *Requirement to renew OHS recognition every two years*
- *Practices may opt out of the OHS recognition process and forego enhanced payments specified by the primary care spend target*

Erin reiterated that the practice team recognition program proposal would not impact the DSS PCMH+ program. Erin asked for the Subgroup's feedback and reactions.

Discussion:

- Alex Geertsma said the Subgroup could address Karen Hlavac's concerns about specific population needs by adding detail to core functions 4 and 5 and said practices should be expected to expand what has traditionally been done for vulnerable populations (e.g., behavioral health, intellectual and developmental disabilities). Lisa Honigfeld agreed with Alex and said the core functions needed more specificity and clear criteria.
- Shirley Girouard said she was concerned about whether the Subgroup had enough stakeholders representing vulnerable populations such as the elderly and racial minorities. Erin explained that

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OHS has been working with its Consumer Advisory Council to identify additional groups with which to engage in the primary care roadmap. Alex Geertsma suggested reaching out to the patients on the DPH Medical Home Advisory Counsel.

Primary Payment Model Proposal

Michael began introducing a proposed primary care payment model for the Subgroup's consideration. He explained that it was informed by interviews with a broad array of primary care practice organizations and payers. Shirley Girouard expressed concern about discussing payment models without first agreeing on a definition of primary care and several Subgroup members agreed. Alex Geertsma requested the Subgroup begin the conversation about payment models and several other Subgroup members agreed. Michael agreed to introduce the payment model conversation but said the Subgroup would wait to make any substantive decisions until a later meeting.

Michael explained that today primary care practices are largely paid on a fee-for-service basis, potentially with some additional payments for quality improvement after the performance period. Michael said practices in ACO arrangements may also get infrastructure support payments for care management and care coordination. Michael mentioned that COVID-19 saw a decrease in primary care spending because of a decrease in visits, which generated an interest (among some, but not all practices) in receiving payment before, not after, a service is delivered, and on a per-person basis.

Michael summarized the potential benefits to primary care practices of a prospective payment model, in that it offers flexibility, allows for different care modalities, provides a predictable cash flow, and does not transfer significant financial risk to the practice.

Michael presented the proposed primary care payment model for Subgroup consideration:

1. *Primary care practices may opt to receive either:*
   a. *prospective per capita payments for most primary care payments in lieu of FFS payments, regardless of the services delivered during the year to the practice's defined patient panel, with a substantial quality incentive payment opportunity, or*
   b. *fee-for-service payments consistent with current practice.*
2. *Insurers can elect to enhance payments to practices however they like in order to hit the primary care spend target; the mode is not specified in OHS' draft proposal.*

Michael added that OHS has identified proposed parameters for prospective payment implementation, but he would not be reviewing them until the next meeting due to time limitations.

Discussion:

- Shirley Girouard asked what the enhanced payment would be for under the proposed model and said patient mix should drive how practices are paid. Michael agreed that patient mix should influence payment levels and noted the FFS system fails to do so. Michael said OHS' proposed parameters for prospective payment address risk adjustment so more money is being paid to practices who may need more for patients with more complex needs.
- Lisa Honigfeld asked why the model addressed provider performance instead of patient outcomes. Michael clarified that he used the term "performance" to include "outcomes" and other performance measures. He added that the proposed OHS parameters for prospective payment included a common measure set to be used across insurers with a limited number of measures and, to the extent feasible, it would emphasize outcome measures. Lisa suggested focusing on getting more value from pediatric primary care in addition to paying more for it.

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- Alex Geertsma said changing payment models creates anxiety among physicians and suggested looking at the PCMH+ initial mixed payment approach. Michael said that while it is complicated for payers and practices to administer, a combination of prospective payments and reduced FFS payments was certainly an option. He also acknowledged the risk of stinting under a prospective payment model, and the need to protect against it.
- Leslie Miller said capitation was previously a failure because providers felt their time was not being valued by the system and mentioned the administrative burdens. Michael observed that the payment modality for capitation was essentially the same as for direct primary care, while acknowledging direct primary care eliminated insurer administrative requirements.
- Randy Trowbridge said that time needs to be allocated to take care of patients, and the payment model has to reflect that time. Every member of the care team has to be working at their highest level of training and we should be facilitating clinicians to work at their best. One way to do this would be to incorporate functional medicine. Functional medicine has been proven to work—patients and doctors are happy, the costs are less, and the outcomes are better. ~~Randy Trowbridge said the payment model should reflect providers' time investment and also mentioned the value of functional medicine.~~
- Tom Woodruff said Connecticut's state employee plan planned to use episode-based payments for members with chronic conditions and was negotiating them. Tom said the payments would initially be retrospective reconciled with the goal of moving toward prospective payments monthly. Michael asked Tom to share written information with Bailit/OHS to share with Subgroup.
- Rowena Bergmans said she appreciated the concerns about capitation, but said prospective payment is different now because payments are risk-adjusted, IT has improved, outcome measures exist, and prospective payment offers practices flexibility in how to treat patients (e.g., flexibility to buy air conditioners for patients with COPD).
- Alex Geertsma (in the chat) said Direct Primary Care, also called Concierge Care, is great for those with financial resources but is largely unaffordable for the poor, working class poor, and usually the middle class.
- Leslie Miller said she was concerned about doctors assuming risk and expressed a desire for more transparency. In response to Alex Geertsma's comment, Leslie said some of the poor do use Direct Primary Care.

Michael reminded the group that practices will have a choice in payment models and asked the Subgroup to consider the three payment options discussed during the meeting: FFS payments, prospective payments, and episode-based payments for patients with chronic conditions. He indicated the next meeting would focus on the foundational issues raised during the meeting regarding the primary care definition and core practice team functions and then return to the discussion on primary care payment models.

6.	**Next Steps and Wrap-Up**	**Hanna Nagy**
	The next Primary Care Subgroup meeting is scheduled to take place August 24th at 1pm.	
7.	**Meeting Adjournment**	**Hanna Nagy**
	Karen Hlavac made a motion to adjourn the meeting. Rowena Bergmans seconded the motion. There were no objections. The meeting adjourned at 2:59pm.	

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