Primary Care Subgroup Meeting
September 28, 2021

Meeting Date	Meeting Time	Location
September 28, 2021	1:00 pm – 3:00 pm	Webinar/Zoom

Participant Name and Attendance

Members Present:		
Lesley Bennett	Karen Hlavac	Dashni Sathasivam
Rowena Bergmans	Lisa Honigfeld	Marie Smith
Christine Cappiello (present for Theresa Riordan)	Ken Lalime	Dr. Elsa Stone
Stephanie De Abreu (present for Stephanie Caiazzo)	Dr. Leslie Miller	Dr. Randy Trowbridge
Heather Gates	Dr. Naomi Nomizu	Lisa Trumble
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	Jeannina Thompson, OHS
Members Absent:		
Dr. Seth Clohosey	Dr. Alex Geertsma	Rachel Southard
Dr. Mario Garcia	Hugh Penny	

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

	Agenda	Responsible Person(s)
1.	**Welcome and Roll Call**	**Hanna Nagy, OHS**
	Hanna Nagy called the meeting to order at 1:03PM. Jeannina Thompson administered the roll call.	
2.	**Public Comment**	**Hanna Nagy, OHS**
	Hanna Nagy invited public comment. None was voiced.	
3.	**Approval of the July 27th and August 24th Meeting Minutes**	**Hanna Nagy, OHS**
	Karen Hlavac moved to approve the minutes from the July 27th meeting and Lesley Bennett seconded. The minutes were approved. Karen Hlavac moved to approve the minutes from the August 24th meeting and Lesley Bennett seconded. The minutes were approved.	
4.	**Follow-ups from July 27th Meeting**	**Michael Bailit, Bailit Health**
	Michael Bailit reviewed the meeting agenda. Michael said the meeting would be focused on revisiting payment models and discussing barriers and strategy to address barriers. **Discussion:** • Shirley Girouard asked whether OHS knew what percentage of health care dollars were currently spent on primary care versus specialty care. Michael said there have been three separate efforts to measure primary care spending and OHS is currently undertaking a fourth assessment which will hopefully be brought to the Subgroup at the October meeting. Michael said the current estimate is about 5% of Connecticut's healthcare spending is primary care spending. • Tom Woodruff said a study of the state employee plan found that about 5% of total spend was on primary care. • Michael added that the percentage varies based on market (Medicare, Medicaid, and commercial).	

- Shirley Girouard said it would be helpful to know where the other 95% of spending is going (e.g., being spent on specialty care rather than primary care). Michael said the three main categories of other spending are hospital, other professional, and pharmacy services.
- Leslie Miller said she thought the Subgroup was changing the definition of primary care and said she would like to know the definition of the primary care included in the 5% estimate. Michael said at the next meeting OHS will share the working definition of primary care used for calculating primary care spending (providers and services as defined in claims) and explain the methodology. Leslie expressed concern that the Subgroup was choosing a payment model before deciding how the money would be spent. Michael said the first four steps of the Subgroup's process had focused on determining how the money would be spent, with the payment model discussion introduced later in the process.

Michael continued recapping the discussion and Subgroup member feedback from the August 24th Subgroup meeting.

- Michael said that during the last meeting the Subgroup reviewed and offered feedback on a primary care definition and that OHS accepted the Subgroup's recommendation to adopt the National Academies of Science, Engineering and Medicine 2021 definition for high-quality primary care.
- Michael said the Subgroup members reviewed updated core practice team functions and provided additional feedback. He explained that OHS will finalize core functions based on the group's feedback and then further operationalize details in the future following Roadmap completion.
- Michael said that Subgroup members reviewed a proposal for a prospective payment model, and conversation among the group centered on how extra payments would support practices, questions about the primary care spending target and broad concerns about value-based payments.

Kelly Sinko provided an update on OHS' activities since the August 24th Subgroup meeting. Kelly said OHS had met with the senior executives of the six largest commercial insurers. Kelly said the meetings' goals included requesting payer support for increasing investments in primary care and supporting implementation of Roadmap recommendations. Kelly extended her thanks to the Subgroup members for their thoughtful feedback on the primary care definition and core functions, acknowledged that additional work was needed to operationalize the core functions, and clarified that work will be done after the Roadmap is complete. Kelly that said in October, the Subgroup will review primary care spending data and recommended targets for 2022 through 2024. In November, the Subgroup will review the draft Roadmap for feedback before OHS releases the Roadmap for public comment.

Primary Care Subgroup Meeting
September 28, 2021

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

Primary Care Payment Model Proposals

Michael Bailit reminded the Subgroup that during the August 24th meeting the Subgroup reviewed a proposed prospective primary care payment option.

- Michael said practices would be eligible for enhanced payments under either a prospective primary care payment model or a fee-for-service (FFS) payment model so long as they are seeking or have obtained mastery of the core practice team functions.
- Michael reminded the Subgroup that the Governor's 2020 Executive Order called for increasing the percentage of health care spending going to primary care up to 10% over five years.
- Michael said primary care practices would be prospectively paid a fixed PMPM fee for most primary care services in lieu of FFS payments, regardless of the services provided to the practice's defined patient panel.
- Michael said insurers could elect to enhance payments to practices however they want. For example, payers could increase the PMPM fee or FFS fees, make infrastructure payments to the practices, and/or make quality incentive payments.

Discussion:

- Shirley Girouard asked how the PMPM calculations would be decided. Michael said the dollar amounts would be negotiated between insurers and providers, but added that to achieve the primary care spend target, payments would need to be higher than they have been historically. Shirley asked where the extra money would come from. Michael said the Governor also set a per capita cost growth benchmark, so increased primary care spending would be funded but reduced spending growth in other service categories.
- Rowena Bergmans asked if OHS modeled out the eleven core practice functions to understand how many resources are needed based on a risk-adjusted population to understand the costs needed for those populations. Michael shared that Bailit Health did work with the Agency for Healthcare, Research and Quality to create a tool that practices could use, which could be made available for CT practices.
- Leslie Miller expressed concern that providers would not have leverage in negotiation unless they were in a large health system. Michael acknowledged this was a legitimate concern and said the intent is that the extra 10% spending on primary care is going to benefit independent small practices but added that he thought OHS would need to take steps in collaboration with insurers to make sure it happens. Michael noted that in OHS' conversations with the six insurers they heard a recognition from the payers that independent practices are in need of additional support.
- Lesley Bennett asked if the services covered under the fixed fee had been defined and expressed concern about chronic disease patients and the financial viability of practices. Michael explained that the Roadmap will not be detailed enough to outline operations. Michael noted that the Roadmap does include provisions to support patients with chronic disease, for example, flexibility to spend more time with certain patients and not suffer financially and flexibility to deploy other members of a practice team without needing to worry about reimbursement.
- Marie Smith asked if waste is being measured in CT. Michael said he was not aware of waste measurement in CT but said he was well aware of the large percentage of spending that goes to waste in the healthcare system.
- Lisa Trumble agreed with Leslie Miller's comment on oversight of the payer community and suggested any model needs guardrails for payers. Lisa further pointed out that ACOs are often performing services on behalf of primary care and cautioned against compromising the movement towards value-based payment.

- Leslie Miller expressed concern about capitation and a lack of government oversight. Michael said prospective payments would be voluntary and practices do not have to participate if they don't want to do so. Michael noted that much has changed nationally from when capitation models were first implemented nationally.[1]Brad Richards suggested there was an opportunity to implement value-based payment in a way that benefits providers and patients.

Michael continued recapping the voluntary prospective payment model.

- Michael said the model calls for risk-adjusted payments based on clinical complexity or by age and gender, prospective patient attribution, measures and monitoring practices to protect against stinting and adverse risk, payer should be aligned on contractual primary care quality measures, practice eligibility for substantial incentive payments based on quality performance, data sharing and education.
- Michael said the FFS model would still include alignment on quality measures, eligibility for incentive payments based on quality performance, data sharing and education.

Michael outlined the four alternative payment models proposed the Subgroup and other stakeholders:

1. Capitate common E&M code services only and pay FFS for remaining services
2. Pay reduced FFS and reduced capitation for all services (e.g., the CMS Primary Care First model)
3. Pay FFS for all services and a supplemental capitation payment
4. Chronic condition episode-of-care bundled payments

Discussion:

- Rowena Bergmans asked about risk adjustment, expressing concern about the choice between age/gender risk adjustment and clinical complexity. Michael said existing risk adjustment software is focused on illness burden and projected spending associated for *total* cost of care, not just primary care. Michael acknowledged that age/gender is an imperfect risk adjustment. Michael asked if Rowena recommended using a clinical risk adjustment and removing age/gender alone as an option. Rowena said she thought clinical risk adjustment made more sense.
- April Greene asked about the term "prospective attribution" because attribution is usually done retrospectively in a PPO model. Michael said the slide should have read "prospective notification" rather than "prospective attribution."
- Michael asked Rowena Bergmans and April Greene which payment model they preferred. April Greene said she needed time to digest the information. Rowena Bergmans said, of the models presented, she was leaning toward capitation for certain services but keeping FFS in place for other services, but wanted time to review as well. Christine Cappiello said Anthem needed a bit more time to consider the options too.
- Leslie Miller said doctors are hardworking and unless payment models reward their work it will be reflected in the care provided. Leslie liked Rowena's comments. Leslie said, regarding panels, patients and doctors should find each other. Michael clarified that patients on a panel would be people who have already been seen by the provider.
- Brad Richards said the model should be as simple as possible and that risk adjustment is necessary. Brad said he would prefer the proposed strawman recommendation or Option 1 ("Capitate common E&M code services only and pay FFFS for remaining services"). Brad commented that Option 2 ("Pay reduced FFS and reduced capitation for all services") is not unreasonable but adds complexity and Options 3-4 would be too complex to operationalize in primary care.

[1] https://www.milbank.org/wp-content/uploads/2020/09/LessonforFutureModels_Bailit_v4.pdf

- Heather Gates said she would prefer whichever model allowed behavioral health patients to access primary care. Heather said she preferred Option 1 ("Capitate common E&M code services only and pay FFS for remaining services") and suggested building in comorbid conditions.
- Shirley Girouard said she had no preference for any of the models because she was concerned that primary care services are being delivered in specialty care, but would favor any model that practices feel would work best. Shirley added that retrospective risk adjustment does not work.
- Stephanie DeAbreu said she agreed with Leslie Miller that it is best not dictate any one model and allow providers and insurers to negotiate the terms of the models.
- Lisa Honigfeld favored capitation because it offers flexibility. Lisa mentioned there are a lot of primary care well-child visits in the first few years of life, with tremendous opportunity to make a lifelong impact on health.
- Lesley Bennett expressed concern about the models' administrative burden on providers. She said she was concerned that the FFS and capitated models would not help patients with complex care needs. Lesley said she was interested in hearing more about the Primary Care First model and Tom Woodruff's experience with the chronic condition model.
- Lisa Trumble supported a risk progression track between models. Lisa mentioned that social determinants of health (SDOH) are not considered in the risk adjustment methodologies. Lisa said that administering and managing a capitation payment requires infrastructure to track and reconcile payments. Regarding chronic conditions, Lisa said there is an opportunity to leverage chronic conditions with subspecialties (although primary care providers may not prefer it).
- Dashni Sathasivam said that risk adjustment by complexity can amplify underutilization and underdiagnosis, particularly among communities of color. Dashni said age adjustment tends to ignore the earlier-in-age risk for people of color. Dashni said social risk adjustment is difficult and race adjustment is inconclusive and our ability to do this is only as good as the data, and current data are poor.
- Tom Woodruff described the state's chronic condition episode-of-care bundled model and its contracts with primary care and multi-specialty providers. Tom said he anticipated getting receiving recognition from CMS later in the week. Michael said it would be interesting to hear from some of the primary care groups about their experience with this model during a future meeting. Tom noted that to address the burden on practices they are providing infrastructure to practices to assist with managing the chronic condition episodes.
- Karen Hlavac, advocating for patients with chronic conditions, asked how waxing and waning chronic conditions would be handled, and wondered how specialists would react to the increase in total spending going toward primary care. Michael said he did not know how specialists would respond and said payment models are based on the spending patterns of a large population, not attuned to individual patients with periods of acute illness.
- Elsa Stone expressed concerns about attribution and risk adjustment and the idea of doing both capitation and FFS. Leslie Miller agreed with Elsa and doubted the severity of upcoding.

Addressing Practice Barriers to High-Quality Primary Care

Erin Campbell reminded the Subgroup that in April OHS sought the group's input on structural impediments and other barriers to the delivery of high-quality primary care that need to be addressed or removed for the Roadmap to be successful. Erin shared that OHS grouped feedback into five identified themes:

1. Payment
   - Erin cited examples of payment barriers, including: (a) inflexible payment models, (b) inadequate payment for comprehensive care or time outside of direct care, (c) misaligned models across payers, (d) lack of support for staff training or coordination with social service providers, and (e) Medicaid payment policies.
   - Erin asked whether the Workgroup thought these payment barriers could be reduced through the Roadmap's primary care strategy and/or other action.

Discussion:

- Marie Smith said team-based care members are not compensated in current payment models. Erin agreed that the model should include payment for expanded care team members.
- Randy Trowbridge emphasized the need to spend more time with patients. Randy advocated for the benefits of functional medicine. Erin said one goal of more flexible primary care payment models is to allow practice teams to spend more time with patients.
- Brad Richards said billing complexities can be a major barrier. Brad advocated for more flexible payment models and appropriate risk adjustment. Brad also noted that misaligned models across payers will continue to be a challenge.
- Leslie Miller expressed her frustrations with the administrative burdens of medical care and electronic health records.
- Shirley Girouard said specialty care and primary care are too siloed and should be more integrated. Erin asked Shirley to offer strategies for addressing this barrier. Shirley referenced the health system monopoly and suggested government policy/regulatory change.
- Lesley Bennett suggested standardizing forms to lower administrative burden on physicians. Christine Cappiello said there has been significant standardization from the Affordable Care Act and the CT legislature.
- Lori Pennito mentioned attribution as a potential structural impediment to securing payment under a model other than FFS.
- Shirley Girouard reminded the group to use the phase "primary care provider" instead of "physician."

2. Workforce *(not discussed)*
3. Administrative burden *(not discussed)*
4. Technology *(not discussed)*
5. Access *(not discussed)*

Erin said the Subgroup will either continue discussing the remaining barriers to high-quality primary care and the Roadmap Implementation Plan at a future meeting or will solicit input electronically prior to the next meeting. During the October meeting, the Subgroup will be discussing the primary care spend target.

6.	**Next Steps and Wrap-Up**	**Hanna Nagy, OHS**
	The next Primary Care Subgroup meeting is scheduled to take place October 26th at 1:00pm.	

Primary Care Subgroup Meeting
September 28, 2021

7.	**Meeting Adjournment**	**Hanna Nagy, OHS**
	Lesley Bennett made a motion to adjourn the meeting. Leslie Miller seconded the motion. There were no objections. The meeting adjourned at 2:58pm.	