CONNECTICUT
Health Strategy

Healthcare Benchmark Initiative

Primary Care Spending Target

2023 Performance

A Report Pursuant to Conn. Gen. Statute § 19a-754h

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Commissioner

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Acronym Glossary

APCD	All-Payer Claims Database
DSS	Department of Social Services
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
OHS	Office of Health Strategy
THCE	Total healthcare expenditures
TME	Total medical expense

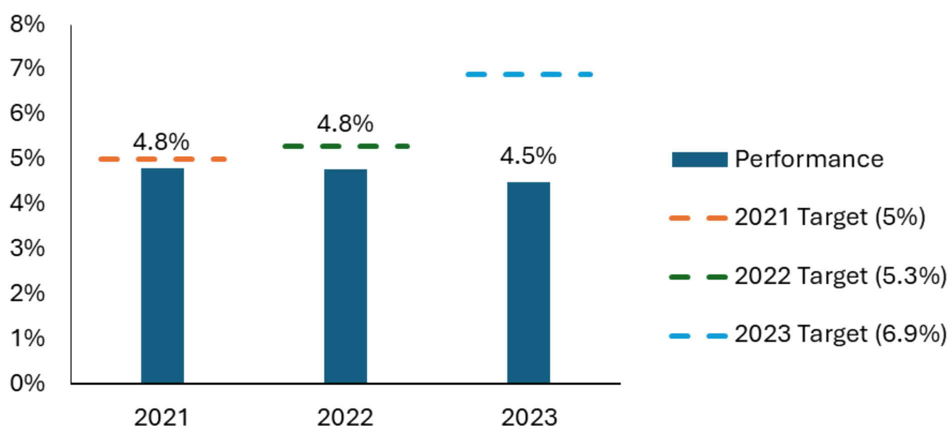
Executive Summary

Connecticut state law (C.G.S. § 19a-754f et. Seq.) requires the Office of Health Strategy to measure primary care spending as a percentage of total medical spending (called Total Medical Expense, or TME). This report assesses primary care spending as a percentage of Total Medical Expense (TME) for Connecticut residents and progress made towards the target.[1] Access to high-quality primary care is essential for patient health maintenance, disease prevention, chronic disease management and care coordination. Primary care investment improves the health of Connecticut residents and has the potential to decrease future healthcare costs. Measuring primary care spending as a percentage of total medical spending can provide stakeholders – including policy makers, healthcare providers, purchasers, and healthcare payers – with actionable data to improve Connecticut's population health and access.

In 2023, statewide primary care spending accounted for 4.5% of Total Medical Expense, falling short of the 6.9% target. This marks the third consecutive year in which Connecticut did not meet its statewide primary care spending target.

[1] Total medical expense is the total cost of care for a patient population for a given calendar year, where cost is calculated for such year as the sum of: all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates; all nonclaims payments for such year, including, but not limited to, incentive payments and care coordination payments; and all patient cost-sharing amount.

2021-2023 Connecticut Primary Care Spending as a Percentage of Total Medical Expense Assessed Against the Primary Care Target



Source: OHS collected data from insurance carriers and the Connecticut Department of Social Services (DSS) .Cost Growth Benchmark Program 2021-2022 & 2022-2023.
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

Statewide, total primary care spending grew by approximately $76 million between 2022 and 2023, to $1.13 billion, representing a per person per month spending increase from $32 to $33. However, because overall healthcare spending grew so much faster, primary care spending in 2023 as a percentage of overall spending *decreased* from 2022.

At a market level, spending in both the commercial and Medicare Advantage markets did not reach the target level. Only Medicaid, administered by the Department of Social Services (DSS), met the target in 2023.

No Medicare Advantage or commercial payers[2] met the target in 2023, and in many cases, the percentage of overall healthcare spending allocated to primary care decreased from 2022.

[2] The commercial payer population includes the state employee health plan, which is administered by Anthem.

Section 1: Introduction

In 2020, Governor Lamont signed an executive order charging the Office of Health Strategy (OHS) with developing and implementing a Primary Care Spending Target to measure primary care spending and promote primary care access. The Primary Care Spending Target is the percent of total medical expenses spent on primary care necessary to improve healthcare access and outcomes for Connecticut residents. The Spending Target is a goal towards which all stakeholders can work.

Primary Care includes a specific list of almost 150 healthcare services ranging from annual wellness and back-to-school visits to influenza and other vaccine administration. These services are included in the spending measurement when they are delivered by a "primary care provider," which includes physicians and nurse practitioners practicing family medicine, internal medicine, pediatrics, and other areas. A full list of primary care procedure codes and provider taxonomy is available in the "Cost Growth Benchmark Primary Care Taxonomy and Procedure Codes" document on the Cost Growth Benchmark Implementation website.

OHS uses aggregate data submitted by payers to calculate primary care spending as a percentage of Total Medical Expenses (TME). Broadly, TME represents the total cost of care for a patient population in a calendar year, including claims-based spending, patient cost sharing, nonclaims payments (such as quality incentive payments), and excludes long-term care spending.

With guidance from an advisory body composed of clinicians, patients, and experts, the Primary Care Spending Target was established in 2020 for calendar years 2021 through 2025. The target for 2021 was set at 5.0%, increasing annually until 2025.

As was the case in calendar years 2021 and 2022, Connecticut did not meet its statewide Primary Care Spending Target in 2023 (see Table 1). Primary care

spending statewide as a proportion of overall spending *decreased* to 4.5%, falling below the levels recorded in 2021 and 2022.

Table 1 Statewide Performance Against the Primary Care Spending Target

Calendar Year	Primary Care Spending Target Values	Statewide Performance
2021	5.0%	4.8%
2022	5.3%	4.8%[3]
2023	6.9%	4.5%
2024	8.5%	--
2025	10.0%	--

Access to high-quality primary care is essential for patient health maintenance, disease prevention, chronic disease management and care coordination. Primary care clinicians provide a variety of preventive care services—including screenings and wellness visits—that can improve health outcomes. They deliver care in private group practices, Federally Qualified Health Centers FQHCs), school-based health centers, nursing homes and in hospital and corporate-owned practices.

Increased availability and access to primary care have been associated with reductions in hospitalizations and

Since moving back to CT in 2017, finding a primary care doctor has been a long, arduous saga. Since 2020, I have had five primary care doctors due to them leaving the state, leaving the practice, and switching to virtual only care. As someone who lives with chronic illness, it's critical that there is continuity of care.

Kristen Whitney Daniels, Shelton

[3] Primary care spending for 2022 is restated in this report as 4.8%, revised from the previously reported 4.9%. Two years of data are re-collected each cycle to ensure consistency across reporting periods. Consequently, the 2022 figures now include adjustments and spending not reflected in the 2024 report. Comparisons with the previously reported 2022 data may show slight variations due to claims runout and other factors that impact spending data over time.

mortality rates.[4,5] Moreover, primary care can promote health equity across income levels, urban and rural settings, and among different racial and ethnic groups.[6,7] Investing in primary care services may also result in cost reductions for consumers by decreasing the utilization of emergency departments, inpatient care, and hospital outpatient visits. [8,9,10]

Connecticut's challenge in increasing its primary care spending as a percentage of total spending can be seen across the commercial, Medicare Advantage and Medicaid markets. In the commercial market, primary care spending has trailed overall spending growth since 2019, growing by 13% compared to an overall spending increase of 25% (see Figure 1).[11] Similarly, in the Medicare Advantage market, primary care spending has trailed overall spending, growing 29% compared to an overall spending increase of 40%

[4] Chang, C.-H., Stukel, T. A., Flood, A. B., & Goodman, D. C. (2011). Primary Care Physician Workforce and Medicare Beneficiaries' Health Outcomes. JAMA:. https://doi.org/10.1001/jama.2011.665

[5] Basu, S., Berkowitz, S. A., Phillips, R. L., Bitton, A., Landon, B. E., & Phillips, R. S. (2019). Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. JAMA Internal Medicine, 179(4), 506–514. https://doi.org/10.1001/jamainternmed.2018.7624

[6] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. The Milbank Quarterly, 83(3), 457–502. https://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2005.00409.x

[7] Shi, L. (2012). The Impact of Primary Care: A Focused Review. Scientifica, 2012, 432892. https://pmc.ncbi.nlm.nih.gov/articles/PMC3820521/

[8] Kravet, S. J., Shore, A. D., Miller, R., Green, G. B., Kolodner, K., & Wright, S. M. (2008). Health care utilization and the proportion of primary care physicians. The American Journal of Medicine, 121(2), 142–148. https://doi.org/10.1016/j.amjmed.2007.10.021

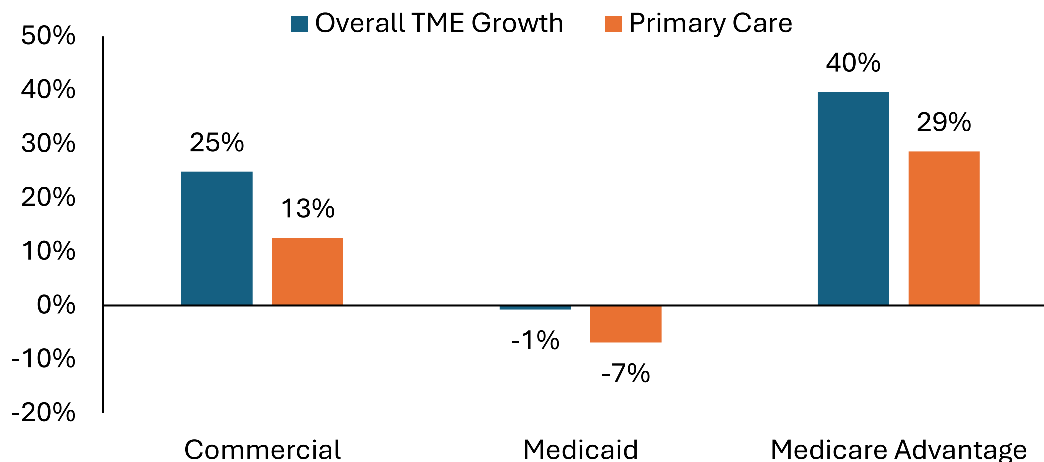
[9] Phillips, R. L., & Bazemore, A. W. (2010). Primary care and why it matters for U.S. health system reform. Health Affairs (Project Hope), 29(5), 806–810. https://doi.org/10.1377/hlthaff.2010.0020

[10] Jabbarpour, Y., Coffman, M., Habib, A., Chung, Y., Liaw, W., Gold, S., Jackson, H., Bazemore, A., & Marder, W. D. (n.d.). Advanced Primary Care: A Key Contributor to Successful ACOs. Milbank Memorial Fund. Retrieved March 5, 2024, from https://thepcc.org/sites/default/files/resources/PCPCC%202018%20Evidence%20Report.pdf

[11] Analysis of Cost Growth Benchmark data from 2019-2021, 2021-2022, & 2022-2023.

since 2019.[12] Medicaid, which has experienced a modest decrease in per capita spending since 2019, saw a 7% decline in primary care spending from 2019 to 2023.

Figure 1 Total Medical Expense growth vs Primary care spending growth, 2019-2023



Source: OHS collected data from insurance carriers and the Connecticut Department of Social Services (DSS), Cost Growth Benchmark Program 2019-2021, 2021-2022, & 2022-2023.
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

The Milbank Memorial Fund's Primary Care Scorecard assesses primary care spending, access, and workforce across states and at the national level.[13] According to the Scorecard, spending on primary care services[14]—defined as

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[12] The Medicare Advantage market experienced growth rates of -4%, 8%, and 7% in 2020, 2021, and 2022, respectively. In 2023, spending increased by 26%, driven by substantial increases in Aetna's and UnitedHealthcare's spending trends. This resulted in a cumulative 40% increase between 2019 and 2023. This growth was greater than that seen in the commercial and Medicaid markets. More information on Aetna's and UnitedHealthcare's Medicare Advantage market performance can be found in the OHS 2025 Cost Growth Benchmark Report.

[13] Milbank Memorial Fund and The Physicians Foundation. (n.d.). The Health of US Primary Care: 2024 Scorecard Data Dashboard. Retrieved March 5, 2024, from https://www.milbank.org/primary-care-scorecard/

[14] The definition of primary care services utilized by the Scorecard differs from the definition used in Connecticut's Primary Care Spending Target. Also, Milbank derives its data from a different source than does OHS. Milbank uses data from the Household Component of the Medical Expenditure Panel Survey, surveys of nonmilitary and noninstitutionalized individuals

outpatient and office-based expenditures for primary care services delivered by primary care clinicians—was 2.9% of total healthcare expenditures in Connecticut in 2022, compared to 4.6% at the national level. Among neighboring states with available data, Connecticut allocated a significantly smaller percentage of its healthcare spending to primary care. For example, New Jersey, New York, and Massachusetts allocated 4.4%, 4.1%, and 5% of their healthcare spending to primary care, respectively.

In other respects, Connecticut's primary care landscape is better than that of most states. For example, in 2022, while 30.9% of adults nationally reported not having a usual source of care, 19.2% of adults in Connecticut did.[15] For children, only 3.3% in Connecticut lacked a usual source of care, about a quarter of the national average. Connecticut's per capita primary care workforce is above the national average. The state has more primary care physicians, nurse practitioners, and physician assistants per thousand people than the national average.

Still, better capacity than other states does not mean that capacity is good. The fact that many residents face a challenge finding a primary care practice accepting new patients serves as the proverbial canary in the coal mine. A December 2021 Connecticut Department of Public Health primary care system assessment found that:

> *"The state has a severe shortage of primary care providers, which is expected to continue over the next several years…The recent growth of retail clinics and urgent care centers helps meet the demand. Still, this short-term follow-up type of practice does not provide the necessary*

and families across the United States overseen by the Agency for Healthcare Research and Quality (AHRQ).

[15] Ibid.

> *continuity and care coordination expected of high standards of care and access."*[16]

Available primary care capacity is worse for low-income residents. In Connecticut geographic areas with higher socioeconomic status, the numbers of primary care physicians, nurse practitioners, and physician assistants significantly exceed the national average for comparable regions, while in areas with lower socioeconomic status, these numbers hover around the national average.[17] Despite Connecticut's overall above-average primary care workforce, disadvantaged communities have not been able to benefit from the same level of resources as their more affluent counterparts.

The issue is likely compounded by the fact that clinicians in Connecticut —including physicians, nurse practitioners, and physician assistants—are less likely to work in primary care as compared to the national average. According to the Milbank Memorial Fund's Primary Care Scorecard, only 22.6% of Connecticut's physicians, nurse practitioners, and physician assistants work in primary care, compared to a national average of 27.2%. In Massachusetts, 24.6% of these clinicians work in primary care, and

> *Having practiced primary care medicine in the town of Bloomfield for close to 40 years, I have seen a lot of changes…Valuable, experienced providers are seeing fewer patients a day…while putting in more documentation time with less compensation. I suffered burnout from that in 2020 which led me to cut back to half time.*
>
> *Two of my partners retired last year, in part due to the ever-increasing burden of documentation and the subsequent loss of the joy of doctor- patient interaction. A lot of knowledge and efficiency left with them.*
>
> *Dr. Ronald Szabo, Shareholder and Secretary/Treasurer of Collins Medical, Board Member Of CMG/ Privia CT*

[16] Connecticut Department of Public Health (2021). Connecticut Primary Care Assessment. https://portal.ct.gov/-/media/dph/primary-care-office/pcna-finaldraft-v8_122821revised.pdf
[17] Ibid.

the rate is over 30% in Rhode Island. More work is necessary to understand why Connecticut has a lower rate of clinicians in primary care and develop workforce solutions.[18]

Finally, there are indications that primary care capacity in the state is shrinking, as many older physicians retire and new physicians aren't replacing them.[19] Nationally, primary care physicians have cited poor work-life balance, insufficient time with patients, dissatisfaction with compensation, and administrative burden (caused by insurer requirements and electronic medical record notation) as key challenges.[20] While additional funding alone cannot resolve all these issues, investments in technology, incentives to encourage more physicians to participate in primary care, and collaboration among payers to reduce administrative burdens may help extend primary care access, especially to individuals living at or near the poverty line and asset -limited, income -constrained, employed households.

Connecticut is one of several states working to bolster primary care investment. Rhode Island, Delaware, and Colorado have set primary care spending targets that are enforced through insurance department rate review.[21] Many other states have either considered or implemented programs to enhance transparency in primary care spending, including California, Maine, North Carolina, and Washington. In California, the Office of Health Care

[18] Milbank Memorial Fund (2025). 2025 Primary Care Scorecard Data Dashboard. https://www.milbank.org/primary-care-scorecard/

[19] Fortuna A. (2023, May 24, updated November 6). What is causing the doctor shortage? Here's why it's only going to get worse. NBC Connecticut. https://www.nbcconnecticut.com/investigations/what-is-causing-the-doctor-shortage-heres-why-its-only-going-to-get-worse/3030878/

[20] Horstman, C. (2024, December 6). A Poor Prognosis: More Than One-Third of Burned-Out U.S. Primary Care Physicians Plan to Stop Seeing Patients. https://doi.org/10.26099/EVWB-8T35

[21] Kona, M., & Corlette Sabrina. (2024, June 28). States Increasingly Use Power Over Commercial Health Insurance to Boost Primary Care Investment. CHIR blog. https://chirblog.org/states-increasingly-use-power-over-commercial-health-insurance-to-boost-primary-care-investment/

Affordability set a primary care spending target that aims to allocate 15% of healthcare spending to primary care by 2034.[22]

The goal of Connecticut's Primary Care Spending Target is to contain healthcare costs, motivate investments in primary care, and improve healthcare access, quality and equity. This report assesses the performance of payers against the 2023 Primary Care Spending Target of 6.9%. The results are presented at the state level, by market (Medicare, Medicaid, and commercial), and for each insurer.

[22] Department of Health Care Access and Information. (2024, October 22). California Sets Benchmarks for Primary Care Investment to Promote High-Quality, Equitable Health Care. HCAI. https://hcai.ca.gov/california-sets-benchmarks-for-primary-care-investment-to-promote-high-quality-equitable-health-care/

Section 2: Assessment of Performance Against the 2023 Primary Care Spending Target

This section of the report presents state, market (commercial, Medicare Advantage and Medicaid) and insurer performance against the 2022 and 2023 primary care spending targets.

Assessment of performance against this target includes claims-based payments, using a procedure code-level definition, and non-claims-related payments, such as infrastructure investments and value-based payments in primary care spending made to:

- Doctors of medicine, doctors of osteopathic medicine, nurse practitioners, and physician assistants that practice (or when practicing) primary care; and
- For care delivered at a primary care site of care, defined as a primary care outpatient setting (e.g., office, clinic or center), FQHC, or via telehealth when delivered by a primary care clinician who practices in a primary care outpatient setting or FQHC

Primary care delivered at urgent care centers, retail pharmacy clinics and via stand-alone, third-party telehealth vendors is excluded. Although these care settings may provide a quick alternative for patients to access primary care-focused services, they don't provide comprehensive, continuous care, including for chronic conditions; coordinate care across multiple providers and may not share data across care settings.

OHS uses data submitted by payers through the Cost Growth Benchmark program to assess performance against the target. Primary care spending is assessed as a percentage of total medical expense (TME), excluding long-term care.

Long-term care services are excluded from TME for primary care spending to make calculations across commercial, Medicaid and Medicare markets

comparable, since only Medicaid covers long-term care and long-term care is a source of significant Medicaid expenditures. This approach is consistent with the methodology previously used by six New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont) [23]

Total medical expense is the total cost of care for the patient population of a payer or provider entity for a given calendar year, where cost is calculated for such year as the sum of: all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates; all nonclaims payments for such year, including, but not limited to, incentive payments and care coordination payments; and all patient cost-sharing amount.

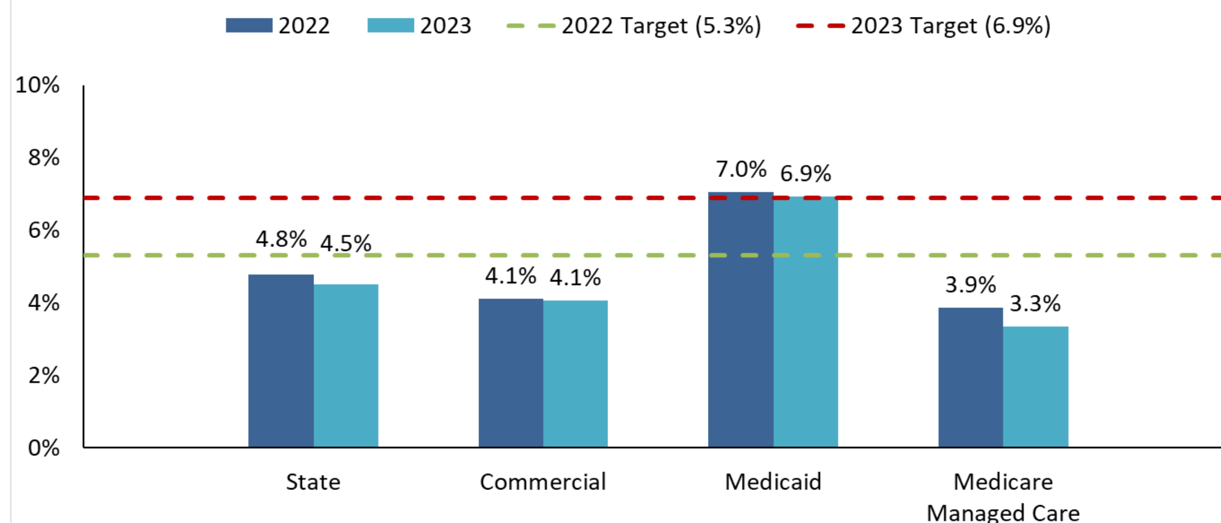
Please note that 2022 data have been re-collected to ensure consistency across reporting periods. Consequently, the 2022 figures now include adjustments and spending not reflected in the 2024 report. Comparisons with the previously reported 2022 data may show slight variations due to claims run-out and other factors that impact spending data over time.

[23] Slusky, R., Conrad, C., Drummond, J., Finison, K., McGraves-Lloyd, K., Spaulding, J., Huffman, D., Nicolella, E., Block, R., & Jones, C. (2020). *The New England States' All-Payer Report on Primary Care Payments*. https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf

Primary Care Spending as a Percentage of Total Medical Expense

The following section assesses primary care spending for 2022 and 2023 against the respective OHS targets of 5.3% and 6.9% at the state, market, and individual insurance carrier levels.

Figure 2 Connecticut Primary Care Spending as a Percentage of Total Medical Expense, Overall and by Market



Source: OHS collected data from insurance carriers and from the Connecticut Department of Social Services (DSS).
Notes: Data are not risk adjusted. Data are net of pharmacy rebates. Data include commercial, Medicare Advantage and Medicaid FFS spending. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

State Primary Care Spending

In 2023, statewide primary care spending increased to $1.13 billion—an increase of approximately $76 million since 2022 (see Table 2). On a per person per month basis, spending rose from $32 in 2022 to $33 in 2023. However, as a proportion of overall spending, statewide primary care declined from 4.8% in 2022 to 4.5% in 2023 (see Figure 2). Despite primary care spending growing by tens of millions of dollars, total healthcare spending increased 7.9% in 2023 (see **2023 Cost Growth Benchmark Report**). Detailed analyses of primary care spending by market and payer are discussed below.

Table 2 Total Primary Care Spending and Per Person Per Month at the State and Market Level

Year	Total Statewide Primary Care Spending	Statewide Primary Care Spending Per Person Per Month
Statewide		
2022	$1,051 M	$32
2023	$1,127 M	$33
Commercial		
2022	$461 M	$27
2023	$494 M	$29
Medicaid		
2022	$388 M	$26
2023	$392 M	$27
Medicare Advantage		
2022	$201 M	$49
2023	$240 M	$54

Source: OHS collected data from insurance carriers and the Connecticut Department of Social Services (DSS).

Primary Care Spending by Market

In the **commercial** market, which includes the state employee health plan administered by Anthem, primary care spending as a percentage of TME remained flat at 4.1% in 2023, well below the target of 6.9% (see Figure 2).Although spending increased by approximately $33 million, overall commercial market spending grew at a comparable rate. On a per person per month basis, primary care spending increased to $29, up from $27 in 2022 (see Table 2).

In the **Medicaid** market, primary care spending decreased slightly from 7.0% of all medical spending in 2022 to 6.9% in 2023 but met the target (see Figure 1). Primary care spending increased by about $4 million, rising from $26 per

person per month in 2022 to $27 per person per month in 2023 (see Table 2). Medicaid, administered by DSS, was the only market in 2023 that met the primary care spending target.

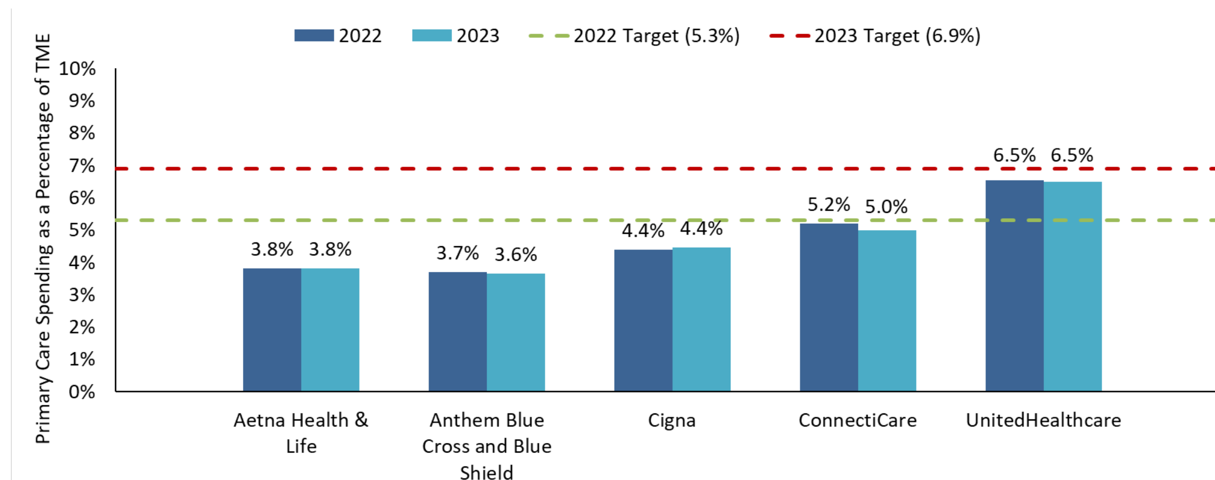
In the **Medicare Advantage** market, primary care accounted for 3.3% of overall spending in 2023, a sharp decline from 3.9% in 2022 (see Figure 1). Although primary care spending increased by $38 million—with per person per month spending rising from $49 to $54—overall Medicare Advantage spending grew at a much faster rate (see Table 2). The 11% increase in per person per month primary care spending did not keep pace with overall Medicare Advantage spending growth.

Primary Care Spending by Insurance Carrier

For the **commercial market**, OHS collected data from five carriers: Aetna Health and Life (Aetna), Anthem Blue Cross and Blue Shield (Anthem), Cigna, ConnectiCare, and UnitedHealthcare. Data are age/sex risk-adjusted, and spending is truncated to limit the impact of high-cost outliers.

No payer met the primary care spending target for 2023 (see Figure 3). In 2023, primary care spending as a percentage of overall spending across payers ranged from 3.6% (Anthem) to 6.5% (UnitedHealthcare). On a per person per month basis, primary care spending ranged from $21 (Aetna) to $39 (UnitedHealthcare).

Figure 3 Connecticut Primary Care Spending as a Percentage of Total Medical Expense in the Commercial Market, by Payer



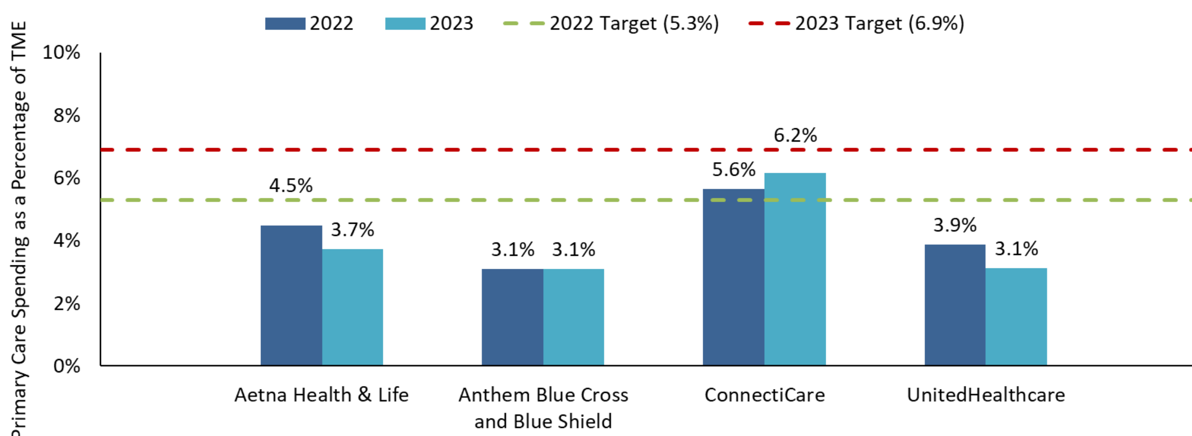
Source: OHS collected data from insurance carriers.
Notes: Data are not risk adjusted. Data are net of pharmacy rebates. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

Two payers—Anthem and ConnectiCare—experienced a decrease in the percentage of spending on primary care. Anthem's share declined from 3.7% in 2022 to 3.6% in 2023, and ConnectiCare's decreased from 5.2% in 2022 to 5.0% in 2023. The percentages for Aetna, Cigna, and UnitedHealthcare remained flat from 2022 to 2023.

For the **Medicare Advantage** market, OHS collected data from four carriers: Aetna, Anthem, ConnectiCare, and UnitedHealthcare. Data are age/sex risk-adjusted, and spending is truncated to limit the impact of high-cost outliers.

No Medicare Advantage payer met the primary care spending target in 2023 (see Figure 4). In 2023, primary care spending across payers ranged from 3.1% (Anthem and UnitedHealthcare) to 6.2% (ConnectiCare). On a per-member-per-month basis, primary care spending ranged from $43 (Anthem) to $69 (ConnectiCare).

Figure 4 Connecticut Primary Care Spending as a Percentage of Total Medical Expense in the Medicare Advantage Market, by Payer



Source: OHS collected data from insurance carriers.
Notes: Data are not risk adjusted. Data are net of pharmacy rebates. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

Two payers experienced marked decreases in primary care spending as a percentage of overall TME. Aetna's share dropped from 4.5% to 3.7%, and UnitedHealthcare's decreased from 3.9% to 3.1%. Both Aetna and UnitedHealthcare also reported high overall spending growth in 2023 for their Medicare Advantage line of business (see **2023 Cost Growth Benchmark Report**). In contrast, ConnectiCare's primary care spending increased from 5.6% to 6.2%, while Anthem's percentage remained unchanged at 3.1% in 2023.

Section 3: Special Focus - Office of the State Comptroller Primary Care Initiative

The Office of the State Comptroller (OSC) operates the state employee, retiree and partnership plan, covering more than 241,000 lives. Following the lead of the Office of Health Strategy's healthcare benchmarks and primary care spending target, OSC invested significant new resources in primary care through:

- value-based contracting;
- coordination between carriers and clinical provider groups;
- setting quality benchmarks; and
- providing incentives to improve performance.

OSC invested in building care coordination teams to support these investments. The OSC Primary Care Initiative (PCI) gives participating provider groups enhanced care coordination fees, shared savings and quality bonus opportunities to invest in activities aimed at improving population health and reducing overall health care costs.

The PCI incentivizes participating provider groups to focus on 11 core primary care functions. Anthem, which administers the program, provides PCI groups with robust reporting and guidance on improved care coordination and quality improvement. For example, some PCI groups have invested their enhanced funding to hire additional staff that provide enhanced care coordination for their patients in the form of increased follow-up and improved medication reconciliation post-hospital discharge.

The PCI has two main components:

- **Care Consultant Teams -** The PCI funds dedicated Care Consultant Teams with Anthem that bring extensive knowledge and experience to the state's primary care initiative, quality improvement, and practice transformation goals. The dedicated PCI Care consultants, most with

clinical backgrounds, have experience in direct care and are well-versed in health care data collection, quality measurement and reporting.

Each contracted PCI group has a dedicated care consultant that works closely with their population health, administrative and clinical teams to provide medical cost and quality reporting that helps guide the contracted PCI groups to develop goals and identify potential opportunities for improvement. This includes, for example, care that attributed patients receive outside of their primary care network – which has led to a better understanding of attributed patient care throughout the care continuum. In addition, the team's provider relations director and contract specialist support the value-based program, including the administration of non-claims-based payments, the use of OSC's claim payment data to track medical cost trend, and the development of continuous program improvement opportunities for the PCI.

- **Care coordination payments and quality bonuses -** An enhanced per member per month (PMPM) care coordination payment was introduced with this initiative. In addition, bonuses for high quality performance using the Healthcare Benchmark Initiative Quality Council-endorsed quality measures of up to $3 PMPM were made available to participant groups. Unrealized funds from these quality bonuses were allocated to an excess quality bonus pool and are equally distributed to groups in the top quartile of quality performance. For example, Anthem's existing commercial care coordination fee (CCF) of $1.50 PMPM plus additional state supplemental payment program CCF of $12 PMPM, creates a new base CCF of $13.50 PMPM for the state's value-based program. This base amount is then risk-adjusted through a standard prospective process for final payment amount.

Quality bonus payments for PCI groups in 2023 totaled an estimated $2,476,584, with *excess* quality bonus payments totaling $838,933 for performance on adult measures and $156,922 on pediatric measures. These excess quality payments were distributed among four top-performing PCIs for 2023.

Taken together, these investments in care management, quality and incentives brought the state employee and partnership plan's spending on primary care up to 7.5% of TME for 2023, exceeding the state target of 6.9%, compared to the rest of the commercial market, which was 4.1% for 2023.

The innovations and investments in primary care made by the Office of the State Comtproller provide evidence that value-based contracting, care coordination, and improved data completeness of quality measurements can yield positive shifts in health care. Other payers may look to this model to rebalance primary care spending.

Conclusion

In 2023, only 4.5% of Total Medical Expense (TME) in Connecticut was allocated to primary care—well below the 2023 target of 6.9%.

- No payer in the Medicare Advantage or commercial market met the primary care spending target in 2023.
- Medicaid was the only market that achieved the target, with 6.9% of all spending allocated toward primary care.

The target increases to 8.5% for 2024 and 10% for 2025. Since the inception of the primary care target the percentage of payer spending allocated to primary care has regressed. The percentage allocated has dropped in all three markets since 2020. While absolute primary care spending has grown over time, spending on hospital services and retail pharmacy has grown faster. If current trends persist, primary care spending will fall far short of the 2025 target of 10%.

These targets were established to boost investments in primary care and improve access to and quality of care for Connecticut residents. However, in 2023, primary care spending accounted for a smaller share of overall spending than it did in 2022 or 2021, indicating that significant efforts are needed to rebalance healthcare spending towards primary care and away from costly acute care. Lack of progress towards the primary care spending target over its first three years indicates that additional action will be needed if the policy objective to rebalance spending in Connecticut's health care system and invest more in primary and preventive care is to be realized.