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ADVANCING INTEGRATED HEALTHCARE

Policy Report

Comprehensive Primary Care in Rhode Island—*Responding to the Emergency and Reorienting Health Care Delivery Post COVID-19*

Overarching Vision

All Rhode Islanders have a designated primary care provider that delivers Comprehensive Primary Care (CPC) and supports improved health and health equity. CPC includes integrated BH and community health workers that can outreach high-risk patients and at-risk children and families with social needs. All patients are supported to receive the right care, at the right time and right place. Healthcare quality and patient outcomes are carefully monitored through a standard set of metrics, including quality measures, risk adjustment and attribution**.** Primary care capitation is the dominant model of payment for CPC practices and there are strong community-clinical linkages. Hospitals establish strong connectivity to primary care and Health Equity Zones (HEZs)/Community Based Organizations (CBOs) to reduce unnecessary ED visits, and improve communication and care coordination with reduced readmissions. Standards for primary care/specialist collaboration are defined and implemented. Rhode Island becomes a preferred State to work as a primary care provider.

Background

Rhode Island has assigned a central role to primary care within the State's strategy to improve population health and health equity, improve health care quality, and reduce costs. Collaboration between primary care providers, payers, and the State is the hallmark of Rhode Island's approach to construct a strong system of primary care that is capable of influencing these outcomes.

Led by the Governor, the RI Department of Health (RIDOH), and other state agencies, RI has mounted a strong and effective response to the COVID-19 crisis. Assisting that response has been a vibrant and cohesive primary care/multi-payer collaborative, CTC-Rhode Island, that has enabled primary care practices to respond rapidly.

However, the novel coronavirus (COVID-19) pandemic has exposed and exacerbated existing weaknesses in Rhode Island's primary care system. These weaknesses include the failure of the fee-for-service payment system, the inadequacies of Medicaid reimbursement, and the need for greater community-clinical system collaboration and linkages—all impact Rhode Islanders' health and well-being currently and in any future crisis.

The Governor and the State recognize the current crisis offers opportunities to reorient the health care system to increase system resilience and strengthen primary care and have asked CTC-Rhode Island to develop recommendations for reorienting the system. This report responds to that request. A corresponding detailed workplan is available upon request.

Methods

Throughout the crisis, multiple forums are occurring to provide feedback and keep the health care system informed. On May 1 and May 15, 2020, CTC-RI hosted large primary care stakeholder forums that engaged the primary care community, health plans, state agency staff and non-profit stakeholders. The forums focused on how to accelerate transformation and innovation in primary care delivery in order to improve primary care cohesiveness in response to the COVID-19 crisis, improve resiliency in health care delivery going forward, and to consider what hospitals and specialists could do to support strong primary care. Systems of Care (SOC) and other groups have also shared best practices since the crisis began.

We use the information gathered through these forums and meetings to provide the primary care perspective regarding system needs overall and systems needs during the current COVID-19 outbreak and any future COVID-19 waves or health care crises. As such, the following section reflects stakeholder views and is not intended to be a comprehensive description of the COVID-19 crisis.

Present Needs and Recommended Actions

1. Need: To remain viable during a public health crisis in which utilization is decreased**, primary care needs a stable, capitated payment system** and Medicaid reimbursement rates consistent with Medicare rates.

- **Ensure financial stability of all primary care practices.** Special attention to community pediatric practices is needed. **One-time payment** to practices serving children, based on panel size equivalent to $3 PMPM for 3 months. Participation in the vaccination project is required (see below).
    - The FFS payment structure has resulted in a cash flow crisis that is threatening the financial viability of many primary care practices, especially community pediatric practices.
- Enhance health equity by **increasing Medicaid payment** rates so that rates have parity with Medicare.
    - Stakeholders report low Medicaid payment rates are an important factor in primary care financial instability prior to and during the COVID-19 crisis. Poor payment contributes to health inequities and the inability to adequately meet the needs of poor and minority families in the comprehensive primary model. There are reports of layoffs or furloughs in many adult and pediatric practices; even the more sophisticated practices are seeing decreased monthly revenue. The situation for smaller practices, not affiliated with a SOC needs further investigation. The RI American Academy of Pediatrics chapter and RI Medical Society are two organizations specifically working on this issue.
- **Accelerate the transition to primary care capitation** including appropriate payments for integrated behavioral health, pharmacy, and population health interventions (community health workers (CHWs) and Community Health Teams (CHTs)) as a more stable payment methodology.
    - RI can build on a current "baseline" capitation model for commercial and Medicare Advantage plans based on the 2017-2018 work from OHIC and current health plan capitation models. This is critical in supporting responsive, flexible, high-quality primary care now and in the future.
    - Special considerations need to be made for pediatric primary care capitation. Calculations simply based on past revenue, quality bonuses, and care coordination fees will not provide adequate funding to meet family social and behavioral health needs for practices that serve pediatric patients.
    - FQHCs need special consideration for Medicaid capitation but could learn from their commercial lives and the ongoing state collaborative as well as add their lessons learned.
    - Health plans can calculate an initial Per Member Per Month (PMPM) payment. An aggressive target for the proportion of primary care paid by capitation for commercial and Medicare Advantage plans could be set for January, 2022 on top of current efforts. We want to support as many practices as possible to reach over 60% of their patients under capitation.
    - With proper technical assistance and MCO collaboration, the work in other states and regions could be leveraged to fast-track the efforts for Medicaid including optimizing their Federal waiver, maximizing the potential for federal match, and other operational considerations. July 1, 2022 or sooner could be a reasonable goal for MCOs to contract with non-FQHC practices for both children and adults. This would help those practices reach the "tipping point" for capitated lives.
    - Quickly calculating "what it should cost" from a "bottom up" approach for CPC can provide important information. A strong RI CPC payment and delivery model can help strengthen primary care training, attract PCPs to RI, and expand the primary care workforce.
    - Adopting the principles and scope of a comprehensive primary care model is an important

first step. We can also actively work to define a PMPM payment that also supports clinic–community linkages and better incorporates Health Equity Zones (HEZs) and Community Based Organizations (CBOs) into care delivery. Innovations in health care delivery will require appropriate work force development efforts and new skills training including integrated behavioral health and expansion of the role of community health workers and community-based behavioral health support for high-risk patients and families.

- Operationalize **a set of common standards**, including quality measures, risk adjustment, attribution **to guide the capitation process.**
- Finalize and implement the **RI Delivery and Payment Model for Comprehensive Primary Care.**
    - To support the new model, sponsor a Health Care Innovation Collaborative to finalize and fully implement the RI delivery and payment model for Comprehensive Primary Care.

2. Need: The COVID-19 crisis disrupted the continuity of essential preventive care. **Practices need support to reopen and patients need encouragement to return to regular care.** We should strive to never again be unprepared for a pandemic.

- Ensure practices have an **adequate supply of personal protective equipment** (PPE) and develop systems to monitor supplies.
    - PPE supplies for primary care offices need to be closely monitored as they return to more in-face patient visits and ensure practices receive the **technical training needed** to maintain clean equipment and facilities.
- Expand current CTC/PCMH Kids meetings to **support all RI practices and CHTs** as they increase in-person visits to include sharing of best practices and technical assistance for scheduling, training on use of PPE, cleaning, and facility maintenance.
- **Ensure high levels of pediatric vaccinations** during and after the crisis through a CTC/PCMH Kids learning collaborative utilizing KIDSNET data. The Collaborative will monitor practice and statewide vaccination rates and other quality measures.
    - Stakeholders identified deferred pediatric vaccinations as a concern. Measles, mumps, rubella vaccination rates were down 40% in March with only the second half of the month affected. Many RI practices that serve children are utilizing KIDSNET data to prioritize scheduling children in need of vaccination for the planned increase of in-person visits.
- Coordinate **public service announcements** concerning the importance of having a primary care provider and the **safety of returning to primary care**.
- **Acknowledge and seek to address provider and patient uncertainty and trauma** regarding the duration and true scope of the pandemic–trauma from COVID-19. The effects of this pandemic likely will be felt for years.

3. Need: Patients need access to primary care and behavioral health telemedicine during a public health crisis and other times when in-person visits are not feasible.

- **Promote clear, consistent multi-payer statewide telehealth and remote monitoring policies with sustainable payment** that incorporate appropriate telehealth use as an essential benefit.
    - The FFS primary care payment system and lack of investments in infrastructure meant practices scrambled to shift from face- to-face visits to **telehealth/medicine** visits.
    - Currently most practices are doing the bulk of visits remotely and in-person patient visits as needed, for example, well-child checks with immunizations for children under two years-old and patients with acute needs. Practices with integrated behavioral health (IBH) are

providing care through telephone and video conferencing. Particularly during this crisis, there has been an increase in patients with behavioral health and social needs. It is essential that any new policies and payment structures address telemedicine for integrated behavioral health.

- Payment parity for audio-video visits and telephone-only visits as well as waiving of patient co-pays helped in the short-term crisis. Most practices within SOC have, or are adopting, HIPAA-compliant platforms for video visits.
- Internet access and technology have proven to be a challenge for some patients and should be addressed.

- **Launch a comprehensive team-based telemedicine and home monitoring initiative** to guide practices from current rapid response telemedicine efforts to a best practice, sustainable, organized and protocol-based effort.
  - Using the expanded clinical team in this initiative will improve efficiency and effectiveness.

4. Need: We need to continue to **strengthen system efficiencies** to effectively respond to COVID-19 and any potential additional waves of the pandemic. Particularly, the pandemic exposed limitations of primary care/specialist/hospital care coordination; tracking COVID-19 test results; and pediatric vaccinations.

- Align hospital incentives to **support better communication and coordination with primary care,** HEZs and CBOs**.**
  - There have been longstanding challenges in ensuring high-quality and safe handoffs between hospitals, community providers, and CBOs. Hospitals lack simple procedures that encourage access of practice and community-based care coordinators for patients regardless of system affiliation.
  - Reorienting hospital and specialist focus to support primary care will improve patient care and population health.
- Endorse **statewide standards** and align incentives to support **primary care/specialist collaboration.**
  - Communication between primary care and specialists too often is haphazard and inadequate.
  - A focus on reducing **low value care** will improve patient safety and help lower costs.
- **Leverage Current Care** to maximize tracking of COVID-19 test results and reduce practice administrative burden. **Support centralized data flows, opt-out rules, and other improvements for Current Care** to maximize value and effectiveness.
  - Receiving COVID-19 test results for primary care patients has been resource-consuming and difficult. Progress has been made through Current Care although but there is still more to do. The opt-in nature of Current Care has hampered the effectiveness of the response.
- Consider if the pediatric **vaccination monitoring infrastructure** can be used for contact tracing for COVID-19 and future public health emergencies.
- Explore using Community Health Teams to support contact tracing and to connect patients to care.

5. Need: To support health equity, ensure continued funding for a <u>core statewide, multi-payer</u> Community Health Team network (CHTs) and an ongoing collaborative to optimize Community-Clinical linkages**.**

- Continued funding to **ensure access** to community health workers (CHWs) and community-based behavioral health linked to primary care to support **high-risk patients and families**.
  - The role of community health workers and community-based behavioral health linked to primary care to support high-risk patients and families is more critical than ever in the COVID-19 emergency and beyond. CHTs serve those vulnerable populations most

adversely impacted by COVID-19, including those affected by a substance use disorder.
    - A recent evaluation by Brown School of Public Health of a mature multi-payer CHT demonstrated a statistically significant **reduction in total cost of care** of over $6000 per year per member served!
- Institute a sustainable hybrid model that supports both practice/SOC based CHTs and a core place-based CHT network.
- Establish an ongoing **statewide collaborative** building on the current **Diabetes Health Equity Challenge**/Pathways to Population Health effort to include all CHTs, HEZs, SOC, Health Plans, and state agencies to provide a venue for ongoing learning and innovation, standardization of data, and reduced administrative burden for community-clinical partnerships. New payment strategies are also needed to scale up the use of CHWs as part of the COVID-19 response.

6. Need: RI needs to maintain and grow the primary care work force to meet future demands.

- **Create an environment where primary care providers want to practice.** This environment includes competitive salaries, a delivery system that provides patient-centered care, and supports providers with low administrative burden.
- Increase **Graduate Medical Education primary care training slots**.
    - There are over 700 Graduate Medical Education (GME) positions at hospitals in Rhode Island, however less than 100 primary care physicians being graduated in Family Medicine, Internal Medicine, Pediatrics, and Medicine-Pediatrics each year. RI will need to address this deficiency and ensure that an adequate balance exists in statewide GME training.

Summary

As a public-partnership, CTC-RI is honored to be given the opportunity to inform how the Governor and the State move forward in strengthening and reorienting the State's healthcare system. While the COVID-19 crisis exposed cracks in Rhode Island's system, it also showed the healthcare system to be fundamentally strong. The structure is in place to move forward to realize the system's full potential.

CTC-RI agrees that Rhode Island has the responsibility to address the shortfalls of its delivery system. We can transform health care delivery to improve high-quality and affordable care that increases access to primary care and needed services; responds to the increased burden of social and emotional stressors; improves health equity and health outcomes; and improves population health. CTC-RI also believes that incorporating the patient, family, and community perspective is a pillar of Comprehensive Primary Care. Aligning payment mechanisms with these priorities provides the best framework for success. These are efforts to help define and pay for the "RI Model of Comprehensive Primary Care" in the context of health system transformation. A strong primary care payment and delivery model also will help RI practices retain and recruit primary care providers.

A properly funded statewide system that promotes vibrant and comprehensive primary care, including integrated behavioral health (IBH), pharmacy, and strong community linkages (including Health Equity Zones, schools, and other sectors) will lead to better outcomes in cost and quality and improve health equity. The technical knowledge exists to organize such a system, including how to achieve integrated HIT. Our knowledge and sophistication have come a long way over the years and continues to evolve.

CTC-RI Work Plan: Comprehensive Primary Care in Rhode Island: Responding to the Emergency and Reorienting Health Care Delivery Post COVID-19

Need #1: Create a stable, capitated payment system and establish Medicaid-Medicare parity			
Key Activities	***Deliverable***	***Date***	**Key Measures**
Define Comprehensive Primary Care • Leverage existing CTC-RI Clinical Strategy Committee • Develop a consensus definition • Define standard set of metrics • Expand primary care capacity for IBH and CHTs • Work with State partners on C19 relief payments for practices in need and Medicaid parity for pediatrics	RI definition of Comprehensive Primary Care (CPC)	By August 2020	• Measure and track % of patients of practices covered by primary care capitation • Cross walk/align with Medicare CPC+ • Expand # Integrated BH practice sites • Increase # primary care linkage to CHTs • Expand # practices maintaining telemedicine services • Cares Act funds provide one-time pediatric practice payments based on practices panel size and payments from same 3-month period during 2019. Assumes participation in Vaccination Collab • Significant move to parity between Medicaid and Medicare especially for pediatric practices • Primary care practices report to State on financial sustainability
Accelerate Implementation of Primary Care Capitation • Conduct a bottom up analysis of PMPM required to deliver full range of primary care services, review with key stakeholders • Adjust capitation for medical and social risk factors • Pilot multi-payer pilot with 10 to 20 Primary care practices where capitated payments represent 60% of total practice revenue	Bottom up PMPM analysis Define risk adjustment Interim evaluation of capitation pilot Final progress report	Dec 2020 Dec 2020 Dec 2020 June 2021	• Capitation payments to primary care uses risk stratification based on medical and social complexity • Standardize quality metrics across payers on state wide goals • Set a target for the number of primary care physicians in RI on population and panel size and monitor progress to goal • Pilot practices have a minimum of 60% of practice panel based on capitation contracts

Need #2: Provide support to practices as they reopen and encourage patients to return to regular care			
Key Activities	***Deliverable***	***Date***	**Key Measures**
• Establish a primary care collaborative to **support re-opening** and sharing of best practices and technical assistance on use of PPE, cleaning and facility maintenance.	Re-opening tool kit	June 2020	• Practices establish a PPE plan • No practices are without necessary PPE when needed
• Establish a pediatric collaborative to ensure timely **pediatric vaccinations** during and after the crisis • Develop and implement a quality improvement initiative which uses KidNet data to address vaccines/immunizations; lead screening and school readiness	Vaccination report	Jun 2020 Sep 2020	• Use KidsNet to establish baseline gaps in vaccinations and track against target threshold to be determined by pediatric collaborative stakeholders • Payments to practices serving pediatric patients assume active participation and goal setting in vaccination collaborative
• Inform the development **of public service announcements** promoting value/safety of primary care and hospitals for important medical treatments	PSA message	Sep 2020	• State responsible for deploying PSA

Need #3: Increase access to telehealth/telemedicine through provider training and payment support			
Key Activities	***Deliverable***	***Date***	**Key Measures**
• Launch a comprehensive team-based telemedicine initiative to institutionalize telemedicine as a regular mode of care delivery. • Partner with NE Telehealth Resource Center to host ECHO learning webinar series geared to practice needs • Implement a new 12-month telemedicine and remote monitoring learning collaborative focused on high risk chronic care patient with selected practices (#TBD) and community health teams (8). • Leverage current learning collaboratives to incorporate telehealth delivery options in pediatric and adult integrated behavioral health and pharmacy quality improvement initiative.	Telemedicine practice facilitation and technical assistance	July 2020	• # of practices that maintain telemedicine as a mode of care delivery • # of practices using HIPPA compliant telemedicine tools
• Promote standard telemedicine and remote monitoring policies with sustainable payments • Assess potential to waive patient co-pays on telehealth visits.	Telemedicine policies and payment documentation	Dec 2020	• % of telemedicine claims (APCD) compared to in person visits
• Work with RIDOH to explore whether Community Health Team staff (e.g. community health workers) could be used to support contact tracing and connecting patients to primary care	Assessment report.	July 2020	• If yes, develop and implement plan for training for Community Health Team staff to do contact tracing

Need #4: Strengthen system efficiencies			
Key Activities	***Deliverable***	***Date***	**Key Measures**
• Establish a multi-payer/multi-stakeholder **hospital collaborative to build on best practices to reorient hospital and emergency department workflows to support care coordination and communication** with all primary care providers regardless of system affiliation and to improve coordination and support of Health Equity Zones/Community Based Organizations to better serve high risk individuals and help improve social determinants of health • Mobilize primary care practices as an arm of the acute care system. Allow patients who arrive at the hospital Emergency Departments to be triaged to the primary care office when appropriate. • **Align hospital and specialist incentives** to better motivate care coordination with primary care offices and to reduce low value care and Iientify and **reduce low value care** (e.g. unnecessary pre-op testing) to increase hospital capacity and reduce unnecessary costs	Establish a joint project plan with deliverables Under Auspices of RI Cost Trend Comm, identify 1 low value care initiative	Sep 2020 Dec 2020	• Meeting convened • Plan established including measures and timelines • Agreement on prioritized areas and tracking measures of low value care aligned with primary care and hospitals • Pre-post measures based on identified initiative (APCD claims data or hospital data)
• Establish a **specialist collaborative** related to hospital collaborative above • Provide incentives to better coordinate care with primary care • Identify and **reduce low value care** (e.g. unnecessary pre-op testing) to increase hospital capacity and reduce unnecessary costs	Establish specialists collaborative deliverables to include establishing statewide standards for PCP/specialist collaboration, work in multi-payer/multi-	Sep 2020 Dec 2020	• Standards established • Plan developed to align incentives • Agreement on prioritized areas and tracking measures of low value care aligned with primary care and hospitals • Pre-post measures based on identified initiative (APCD claims data or hospital data)

Need #4: Strengthen system efficiencies			
Key Activities	***Deliverable***	***Date***	**Key Measures**
	stakeholder forum to agree on methods to align economic incentives and identify 1 low value care initiative		
• Collaborate with RIQI to **leverage Current Care-** maximize tracking of COVID 19 test results and reduce administrative burden • Fully deploy the Current Care dashboards to all primary care providers including new addition of C19 results • Participate in project related to data aggregation, development of high risk registries.	Status report	Oct 2020	• Number of primary care practices with access to CC dashboard • Funding for full deployment of Current Care • Participate in statewide meetings to enhance Current Care for high risk care management in primary care
• Launch a 6 to 12 month expansion of the current **Health Equity Challenge** and use of Pathways to Population Health model to strengthen community- clinical linkages between primary care, CHTs and HEZ to support people who are especially vulnerable to equity gaps in context of COVID 19	Report on results of initial pilot currently underway	Sep 2020	• Pilot measures – linkages to improve health outcomes for diabetics during COVID 19 • Expand to include support for high risk patients and families affected by COVID-19
• Assess whether pediatric immunization monitoring infrastructure (KidsNet) can be leveraged for future public health emergencies like COVID 19	Status report	Dec 2020	• TBD

Need #5: Support health equity through Community Health Teams, and HEZ/CBO collaborations			
Key Activities	***Deliverable***	***Date***	**Key Measures**
• Work with Medicaid, Accountable Care Organizations/Entities, commercial and Medicare Advantage health plans to develop and implement a sustainable model and plan for **multi-payer Statewide Community Health Team access** for all Rhode Islanders at highest risk for poor medical outcomes	Statewide CHT network	June 2021	• Use key metrics already defined by CHT initiative
• Assess use of CHTs staff to contact tracing			• # of staff trained in contact tracing
• Link CHTs with HEZ – expand Health Equity Challenge			• Measure level of expansion

Need #6: Maintain and grow the primary care workforce			
Key Activities	***Deliverable***	***Date***	**Key Measures**
• Create an environment where primary care providers want to practice. Salaries are competitive and the delivery system support primary care with low administrative burden.	Competitive salaries/payments	TBD	CTC-RI will collaborate with State and others who take the lead on this activity.
• Increase Graduate Medical Education training slots	More graduates in primary care	TBD	Same as above