CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

To: Michael Bailit
From: Debra Hurwitz
Date: November 6, 2024
Re: Ideas for Immediate Stabilization of Primary Care Practices in Financial Crisis
CC: Cory King

Following the October 21, 2024 meeting of the OHIC Payment and Care Delivery Advisory Committee, CTC-RI was asked to provide ideas around actions that might be taken immediately to support practices facing an existential financial threat to their ongoing operations of primary care delivery. The recent situations occurring with Thundermist and Providence Community Health Centers (PCHC) may not be isolated events and could be a sign of fragility and instability among other primary care practices. Rhode Island cannot afford to lose any primary care practices, as we already have a shortage resulting in access problems for patients. Below are some ideas provided by Peter Hollmann, MD, other CTC-RI Board members, and the CTC-RI management team.

OVERSIGHT/ORGANIZATION:

- **The state should convene key stakeholders to discuss risk mitigation strategies for primary care practices facing eminent financial failure**. Recommended key stakeholders could include: OHIC, Medicaid, BCBSRI, UHC, NHPRI, Brown University Health (Lifespan) and CNE and may be supplemented with RI Foundation. While the Health System Planning Cabinet work is ongoing, it is focused on a mid- to long-range strategies for the health care delivery system. However, there is the potential that some urgent steps may be required to immediately stabilize some primary care practices and provide support to maintain infrastructure for advanced primary care delivery. The recent Thundermist and PCHC situations could be a sign that other practices are at risk of failure. This group could discuss ways to identify and address these immediate issues, such as loans, pre-payments, grants and services provision, etc.
- **Meeting with the Speaker and House Finance Chair**. We are aware of the austerity measures needed. However, some emergency actions may be needed in the February timeframe. A **Primary Care Stabilization and Relief legislative package** may be feasible that could supplement any emergent measures. This may facilitate an efficient legislative and financial/budget approach to rapidly address imminent primary care practice failures.

FINANCIAL STABILIZATION:

- **This must be equitable, but there can be selective actions based upon the organization in peril and the reason that they are in peril.** For example, if RIPCPC needs something sooner

than another independent practice association (IPA) (e.g. Community Physician Partners (CPP)), CPP needs to be satisfied with that. **Any loss of primary care creates much burden on those remaining**. Phone lines become jammed with people attempting to get appointments, emergency rooms get swamped, and hospital length of stay (LOS) prolonged without adequate follow-up. All have an interest in the welfare of others.

- Prepayments based on past revenue.
- Immediate and, if needed, retroactive requirements that support PCP infrastructure. Primary care infrastructure payments should count as medical expenses and not be at risk or reduced based on shared savings. In other words, it should be guaranteed, even if it may reduce shared savings.
- This should include some minimum level of infrastructure support from Medicaid. This could be jointly funded by the State and health plans. Barry Fabius, MD commented that with the health centers releasing staff, UHC is planning to pick up care management which is cost to the health plan. It is well established that health plan case management is less effective than practice-based care management, so they should be willing to spend some money on the practices. Rebecca Plonsky, CEO of IHP, raised issues with accountable entity (AE) payments which are also relevant--although it seems to be timing and not an amount issue.
- **Medicare and PCF**: Effective January 1, 2025, per the Physician Fee Schedule Final Rule, Medicare will pay $15 PBPM for those with 1 or fewer chronic conditions; $50 for those with 2+ chronic conditions; and $110 for 2+ chronic plus QMB status. These are Advanced Primary Care Management services—RI practices would all qualify. FQHC also can report these separately. Given the erroneous leakage calculations in Primary Care First (PCF), this is far superior. Further, PCF does not provide information in anticipation of CMS changes and how they will address these codes. G2211 plus these codes will also make Medicare a better payer than Medicare Advantage. Some pressure should be put on plans to consider these, even potentially in lieu of the PMPM. We believe BCBSRI is considering dropping some PMPM payments and allowing the codes for Chronic Care Management services. That is not a substitute in any way. The allowance is effective January 1, 2025. We are not sure why they are doing this unless it is because they do plan to decrease or cease payments. It may be worth asking them. In a recent communication with Mr. Minter (CMMI) PCF practices will be able to use these codes as well. Peter Hollmann, MD, a content expert in this area, is willing to provide education on these codes. These new codes will help some practices. If plans are losing money, and hospitals and practices are losing money on Medicare Advantage, practices will cease participation, as may the health plans. **Proactive planning to avoid patient disruption in 2025 should be a state priority.**

TEACHING HEALTH CENTER GRADUATE MEDICAL EDUCATION (THC GME):

- This HRSA-funded program is extremely effective. Thundermist has made significant investments in establishing a THC residency program in Woonsocket that has recently received accreditation. This program will train 4 medical residents per post-graduate class year (12 per year) and graduate 4 physician residents a year (after the 3-year start-up). **The State, Thundermist and HRSA should immediately get together to be sure this program is not in jeopardy.** Medicaid, RI Foundation and even hospital GME dollars may be available to help short-term. This is a relatively small investment with a big impact. It is also targeted to provide 2,000 visits per year to the most vulnerable in Woonsocket.
- **Secretary Charest mentioned 340B pricing as an issue.** He said that those Certified in Healthcare Compliance (CHCs) no longer have the markup on some drugs and are now subsidizing losses. The

state should look at this situation and consider whether the hospitals can do anything to at least stop net losses, even if they cannot do anything about lost revenue.

TEAM-BASED CARE (TBC) AND CENTRALIZED SERVICES:

- **Primary care transformation and patient access requires interprofessional and multidisciplinary TBC at the practice level**. That said, we should look at what can be done now to preserve TBC even if more is centralized. It is better than not having anyone help with the practices. Some organizations (e.g. RIPCPC) do centralize more than Brown Medicine because the practices are smaller. Some could be centralized at the hospital.
- The goal should be to prevent a backslide from activities that facilitate larger panel management.
- This may include hastening and increasing capitation rates for primary care services.
- This may include fee-for-service (FFS) payments for some Community Health Integration and social determinants of health (SDOH) services (codes that CMS implemented for 2024).
- Commercial plans should pay for community health workers working in primary care or integrated behavioral health.
- Other relief valves may include effects such as MomsPRN and PediPRN where practices are helped. This could include funding for assistance with Health-Related Social Need (HRSN) for high-risk patients--something practices are generally not well-equipped to manage.
- The Certified Community Behavioral Health Clinics (CCBHCs), possibly a solution for some persons with a primary diagnosis of behavioral health conditions, ensure linkages between CCBHCs and primary care practices where appropriate.
- Practices may have other ideas for the following: “I could do more or be less stressed if I only had someone to do XYZ”. This may be where a crisis helps people to shift as we never will have primary care physician to population ratios as existed 20 years ago.
- Secretary Charest seemed to equate teams and infrastructure with pandemic money that is now gone. This needs correction if that is his perception. That may be true for some type of personnel (community health team workers), but not all.

BURDEN RELIEF:

- This could be handled as with the COVID public health emergency.
- Increase payment rates for primary care (both FFS and PMPM).
- January 1 means all PCP to specialist referrals may need renewal and Medicare Part D generally requires many prior authorizations or prescription changes. PCP referrals are largely a waste. They minimally provide better care coordination and there is little gatekeeper financial impact. People occasionally do not attempt to obtain a referral nor defer a service that is probably nonessential. Intermittently, a PCP explains why it is unnecessary and the patient agrees. However, most often the referral is made, medically necessary or not, or is a continuance of ongoing care.
- Practice pharmacists and health plans could unite to minimize burden. But they need a convener who says, “You need to get together and give us a solution in 6 weeks.”
- **Many Prior Authorizations can be stopped**. BCBSRI has a good start. 20% of total PA codes being reduced with a 20% reduction in PA volume for PCPs is not that useful. That is what the other plans did, though we really do not have the data on the impact of what they did. BCBSRI targeted PCP type and they can do more. **More transparency and monitoring of PA reduction and impact on administrative burden is needed**.

- **Pharmaceutical Therapeutic Substitutions**: At a recent CTC-RI meeting, a community pharmacist mentioned that one of the CTC-RI goals which was therapeutic substitution (some are virtually generics e.g. biosimilars, "branded generics") at the pharmacy. This may take statute and if the prescriber is a specialist who does not want to allow it, they do not have to. We would expect some notice to the prescriber office. A formulary of drugs that can be handled this way could be quickly made. For example, a community pharmacist could substitute Lantus and Basalglar. This is PCP-prescribed and would likely not concern the PCP as it is effectively a generic substitution. There are other examples such as with inhalers. We can leave more complex conditions such as Multiple Sclerosis, inflammatory bowel disease, Rheumatoid Arthritis, and their medications, etc. off the list initially as they are almost universally specialist-prescribed.

OTHER COMMENTS/IDEAS:

- The NASEM report calls for Primary Care to be treated as a public good. Massachusetts is considering establishing a primary care trust fund to aggregate/blend funding from multiple payers. The funds will be used to pay primary care providers on a PMPM for patients in their panel.
- In light of the AHEAD model coming to RI, can we pilot a bold and innovative payment approach in primary care so that we are ready when we start in the January 1, 2027 Cohort 3. Tiered models like Massachusetts would be very interesting.
- Payment should be multi-payer and cover the costs of care team members which could include nurse care managers (NCMs), medical assistants, behavioral health clinicians, and community health workers.
    - CHW: all payers reimburse, not just Medicaid. With Medicaid, it needs to be included in Managed Care Organization so there is not the need to obtain a separate Medicaid number. We need to accelerate the time when a newborn gets a number.
    - Pharmacy: Pharmacists do impressive work in helping primary care practices with medication management of complex patients.
    - NCM: Cost of NCMs is supposed to be part of the PMPM payment. CTC-RI no longer has visibility into how NCMs are paid or if the PMPM rates paid to practices include the NCM. Is OHIC tracking this?

- High-quality, affordable, and equitable population health requires access to advanced primary care delivered by a well-trained care team.
- It is difficult to measure return on the investment (ROI) of primary care and especially the contribution of care team members on the ROI.
- We believe the measure of success should be on the preservation of primary care delivery and population health.