**Working Draft**

**Care Transformation Collaborative of RI (CTC-RI)**

**Primary Care Recommendations**

**Submitted to the**

**Health Care System Planning (HCSP) Primary Care Workgroup**

**October 11, 2024**

**Introduction**: The HCSP Cabinet is convening 5 work groups to engage key stakeholders in identifying health care system planning recommendations and setting priorities for a report to be submitted to the Governor and legislative leaders by December 2024.

The work groups are open to the public and include:

1. Primary Care
2. Behavioral Health
3. Social Services
4. Hospitals
5. Long term care

**The Primary Care work group** is co-chaired by OHIC Commissioner Cory King, RIDOH Director Jerome Larkin and Elena Nicolella, President & CEO of Rhode Island Health Center Association. The basis of information they have collected to date includes the recently released OHIC report, [Primary Care in Rhode Island Current Status and Policy Recommendations](https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-12/Primary%20Care%20in%20Rhode%20Island%20-%20Current%20Status%20and%20Policy%20Recommendations%20December%202023.pdf) and the [CTC-RI Primary Care Workforce Task Force Strategic Road Map Report](https://ctc-ri.org/sites/default/files/Primary%20Care%20Access%20for%20All%20-%20A%20Strategic%20Roadmap%20Report%20-%20FINAL_0.pdf) published in January of 2024. They plan to hold 3 meetings and a retreat to develop final recommendations for the report.

Commissioner King has requested from CTC-RI additional recommendations that can be implemented using levers available to state government. CTC-RI leadership has leveraged our multi-stakeholder Task Force to build on the recommendations outlined in the Road Map report. The following additional recommendations have been organized under the framework of the six goals defined in the [CTC-RI Primary Care Workforce Task Force Strategic Road Map Report](https://ctc-ri.org/sites/default/files/Primary%20Care%20Access%20for%20All%20-%20A%20Strategic%20Roadmap%20Report%20-%20FINAL_0.pdf) The recommendations address the critical need for immediate response to the primary care provider shortage and patient access crisis and support increased data collection, reporting and transparency. Equitable healthcare should be the right of all Rhode Islanders and depends on a strong and robust primary care system.

**Short Term Goals (organized based on the goals of the CTC-RI Strategic Roadmap)**

1. **Reform payments** and incentives to primary care providers to create specialty and regional parity.
   1. **Authorize OHIC to conduct a primary care rate review:** Review fee-for-service rates including commercial and Medicaid (both Medicaid FFS and MCOs rates) with a goal of establishing competitive and sustainable rates in Rhode Island. The rate review should reflect services provided by primary care providers e.g. Office and Home E/M, Preventive Medicine, and compare with Massachusetts and Connecticut payers including Medicaid. Rates should be broken out by specialty (pediatrics has differential rates in RI Medicaid). The review should also consider primary care capitation and supplemental payments. Guaranteed payments should be included, but shared savings or payments at risk must be separately noted, if used in an overall assessment. Quality payments should also be separated but may be included in an overall assessment. This request is designed to parallel the Long-Term Services and Supports (LTSS) rate review OHIC did for Medicaid and simultaneously review Commercial Fully Insured and Primary Care Spend definitions and requirements.
   2. Develop and publish a “bottom up” analysis for the cost of team-based care (using cost calculator or another tool). These data can be used in establishing the basis for capitation payments related to the practice’s care delivery team.
   3. As noted above, **reform Primary care capitation (pre-payment) through regulatory and/or legislative action**. Capitation rates should be sufficient to cover costs of team-based care required to deliver “advanced primary care “and should **not** be at risk in shared savings payer contracts with Systems of Care. Primary care practices need to be protected.

**Team based care is critically important for two reasons:**  **First**, **team-based care is necessary to fulfill the functional requirements of advanced primary care delivery** such as care coordination, integrated behavioral health, and screening for health-related social needs (such as housing and food insecurity). In a recent report by the National Health Center Training & Technical Assistance Partners (NTTAP) [“Team-Based Care In Health Centers”](https://3.basecamp.com/3848947/p/rXs6LFAtEUqiMR2qSSRerhtD/vault/7893512421), team members in an advanced primary care practice can include:

* + - 1. Nurse care managers
      2. Medical assistants
      3. Behavioral Health Clinicians
      4. Pharmacists
      5. Community Health Workers – note that in RI Medicaid provides a fee-for-service payment for CHW service. We urge OHIC to support commercial payment for CHWs. Multi-payer payments that can include CHWs as part of PMPM capitation payments is preferred over FFS.

**Second, there is a well-known shortage of primary care providers to serve Rhode Island’s population.** In an effective and well-staffed team-based care model, patient access is enhanced, patient outcomes are improved, team members experience better job satisfaction which leads to better primary care workforce retention. A new Brown University analysis of APCD data shows that we have about half as many PCPs as we need per 100,000 population. (reference: [Primary Care Workforce Assessment](https://public.3.basecamp.com/p/Ka1wmhCFZBeZ7mXytCFb3fk8))

Payments to primary care practices, currently outside of fee-for service payments, must be sufficient to cover the costs to build an effective team, and must be sustainable.

* 1. Align payments for advanced primary care across all payers.
  2. State employees’ health plans should be structured to incentivize members to participate in plans that feature the benefits of having a designated primary care provider. Health plan options can be structured to provide affordable preferred networks in addition to current PPO plan options. The Massachusetts Group Insurance Commission may provide an example of how state employees and retiree health plans can be structured with preferred networks.

1. **Establish baseline data** and performance targets for the primary care workforce using existing and to-be-developed data sources for ongoing monitoring.
   1. Fund resources needed for data collection, analysis and public reporting. For example, the EOHHS ecosystem and other data sources that support primary care (e.g. Primary Care dashboard).
   2. Establish methodologies for accurate monitoring and timely dissemination of baseline and ongoing actionable data related to the primary care workforce, its role in the healthcare system, and population health (including disparities) using existing or to-be-developed methodologies.
   3. Fund development and use of existing or to-be-developed methodologies to identify health equity disparities and social drivers of health and focus on strategies to improve. For example, population health measures show that in RI Hispanics are not doing well on certain health metrics. Data should be posted on websites available to the pubic for full transparency.
2. **Increase the recruitment** of medical students, residents/fellows, nurse practitioners (NPs) and physician assistants (PAs) entering primary care. Support strategies to reduce tuition and educational debt for providers entering primary care practices in Rhode Island.
   1. Expand the Brown Early Identification Program (EIP) to create an expedited, shortened track program for entry into and completion of medical school and residency for RI residents and college graduates committed to practicing primary care in Rhode Island. Eligible students would pay a state subsidized reduced tuition contingent on their commitment to practice primary care. Factors such as zip code of residence (Central Falls vs Barrington) can be weighted to promote workforce diversity.
   2. Establish regional collaboratives with other State Medical schools (CT, MA) to invest in slots for RI students to enter medical school with the intent of practicing primary care in Rhode Island (reference: [WWAMI model](https://www.uwmedicine.org/school-of-medicine/md-program/wwami)). The goal of this program is to provide publicly supported medical education and increase the number and diversity of primary care physicians in a cost-effective way. Development of regional collaborative agreements could be accomplished in a much shorter time frame compared to the time required to build and staff a state medical school, at a much lower cost and will result in a timelier pipeline of new providers.
   3. Require all medical schools, physician assistant and graduate nursing school programs to conduct an annual primary care contribution assessment similar to a hospital community needs assessment and publicly report on its contribution to primary care workforce development to promote transparency and accountability.
   4. Use economic development and innovative tax policies to recruit and retain primary care providers. For example, tax credits for primary care providers/groups who are currently practicing in RI.
   5. Continue to invest in and enhance primary care educational debt reduction programs, e.g. scholarships and loan repayment for Rhode Islanders contingent on practicing primary care in RI.
3. **Expand the primary care workforce to better reflect the state’s diversity** while fostering healthcare equity and inclusion (DEI) for all Rhode Islanders.

* 1. See strategies noted above**.**

1. **Increase the number of high-quality primary care training sites** that are willing to educate the next generation of primary care students.
   1. Develop an enhanced fee schedule for interdisciplinary team-based teaching sites through commercial and Medicaid managed care contractual arrangements or other payment methods to recognize the extra time required by preceptors who provide clinical training to students.
   2. Continue to support funding for the new 2024 legislation enacted to create the Office of Primary Care Training as a mechanism to attract, support and expand the number of community-based primary care sites that provide advanced primary care medical home clinical training to medical, physician assistant and advance practice nursing students.
   3. Provide state-directed funding for community primary care training to achieve a Medicaid match.
2. **Enhance clinical training experiences** within practices using advanced patient-centered medical home (PCMH) principles such as team-based care, integrated behavioral health, population health strategies, and value-based payment.
   1. Continue to support funding for the new 2024 legislation enacted to create the Office of Primary Care Training and provide funding to develop curricula and standards for community-based primary care training sites to include the interdisciplinary components of advanced primary care medical home clinical training to medical, physician assistant and advance practice nursing students. The benefit of this approach is to increase the consistency of training and support a more positive learning environment and impression of primary care as a desirable and rewarding practice.

**Long Term Goals**:

1. Bolder action on health care financing – Define primary care as a public good - establish a basis of what services should be available for all. (i.e. preventive services, immunizations, integrated behavioral health, screening for health-related social needs, etc.) and determine how this model can be supported (primary care trust) and how success can be monitored and reported.
2. Continue improvements in administrative simplification. Primary care administrative burden is well studied as a major contributor to clinician burnout, decreased workforce recruitment, and primary care workforce decline. Conduct periodic follow up on the effectiveness of the health plans’ reduction in prior authorization requirements on primary care administrative burden. Consider development of an annual rating of health plans related to administrative burden.
3. Establish an Office of Primary Care policy