

The Primary Care Marshall Plan

A five-point plan to transform health care in Texas

Report by FTI Consulting and the Texas Academy of Family Physicians
August, 2020

OVERVIEW

The COVID-19 pandemic exposed critical weaknesses in our fragmented health care system. Years of underfunding primary care and public health at the federal, state, and local levels left Texas' health care system ill prepared to handle the ongoing national health crisis.

The pandemic also laid bare health disparities among low-income Texans, particularly Texans of color, who prior to the arrival of COVID-19 experienced higher rates of maternal mortality, chronic disease, and mental illness. COVID-19 made explicit how our public health system fails to overcome social determinants of health.

Inconsistent access and quality, high costs and inequities have long plagued our health care system. Yet, decades of research makes clear that a strong primary care system gives patients continuous access to a primary care physician, and in result, helps them [stay healthy](#), identify and manage chronic conditions [and avoid expensive emergency settings](#) and other costly downstream medical interventions. As we continue fighting the first wave of COVID-19, reimagining how primary care is funded and delivered can improve the health and economic productivity of our citizens, reduce overall health care spending and prepare us for future public health emergencies.

Just as the aftermath of war offers an opportunity to rebuild, the devastation COVID-19 wrought on our health care system and our economy gives us the opportunity to rebuild a better, more cost-effective system of care. And just as the historic investments made under the Marshall Plan after World War II enabled European countries to rise from the ashes of war, today we need a Primary Care “Marshall Plan” to tackle the state’s most pressing health care problems. The entire nation must learn lessons from COVID-19 and rebuild our health care system based on those. Yet, as often is the case, Texas holds unique advantages, challenges, and opportunities for immediate action. State policymakers should seize the chance to fix shortcomings, build a more effective, equitable health care system, and prepare the state for future public health crises.

This five-point plan lays out the specific actions that policymakers should take to transform the Texas health care system through improved access to primary care.

I. PROMOTE COMPREHENSIVE PAYMENT REFORM AND TRANSITION AWAY FROM FEE-FOR-SERVICE

When COVID-19 first emerged in the U.S., local stay-at-home orders and widespread fear kept patients at home, and revenues from in-person visits to physician practices shrank. Most practices embraced telemedicine, but virtual visits did not generate enough revenue to cover operating expenses. Because most primary care practices keep less than two months of cash on hand, the pandemic financially devastated these small businesses. With the pandemic far from over, primary care practices remain economically tenuous.

Among practices that have fared better, many had previously moved away from a [fee-for-service](#) payment model — where physicians are paid based on the number of services provided, or the number of procedures ordered — to a prospective payment system.

Health care spending trends are linked to the way we pay for care and incentivize health care providers. Fee-for-service payment systems reward physicians who deliver high volume, high-cost services while undervaluing comprehensive, continuous, and coordinated primary care services. That payment structure has for decades contributed to the rising cost of health care in Texas and across the country. A [report by the Texas Comptroller's Office](#) found that health care spending rose by an average of 19.7% annually from 2011 to 2015, comprising 43.1% of Texas' state budget in fiscal year 2015. At the same time, reimbursement for high value, [cost-effective primary care services](#) has significantly [declined](#) relative to high-cost imaging and surgical procedures. Care coordination and patient navigation has been reimbursed inadequately, if at all.

Today, experts across the political spectrum agree that reforming the way we pay for care to incentivize quality over quantity could contain ballooning health care costs and improve patient outcomes. During the first wave of COVID-19, practices that depended on patient volumes suffered financially. By contrast, physicians operating under prospective payment systems remained viable businesses and nimble in the care they provided their patients during this unprecedented challenge. The difference offers a stark contrast and present-day case study for some of the pitfalls of fee-for-service care and the advantages of alternative payment models.

Physicians operating under prospective payment systems are generally paid a set amount per patient rather than per service. The payment covers a defined set of services and is issued at regular intervals, typically monthly. This approach is not new; in fact, the Centers for Medicare and Medicaid Services already uses a prospective payment model in the Medicare program for [acute care hospital inpatient stays](#). The payment model is one of the hallmarks of success for Medicare Advantage plans. State Medicaid programs, including a handful of managed care organizations in Texas Medicaid, also [use prospective capitated payments](#) in managed care.

Similar to products like Netflix, prospective payment models offer consumers subscriptions to different platforms, with different content and price structures. While there are numerous prospective payment models, partial capitation — in which physicians are paid a set payment amount for a fixed set of services and take on some risk to keep their patients healthy — is where primary care physicians can thrive.

Prospective payments reward strong care management and better continuity of care for patients, incentivize physicians to keep patients healthy, and are proven to [improve quality while reducing](#)

IMPACT OF COVID-19 ON PRIMARY CARE PRACTICES

A [June survey](#) of about 500 clinicians by the Larry A. Green Center and the Primary Care Collaborative found 63% of primary care practices were experiencing severe or near severe stress, 5% were either temporarily or permanently closed, and 39% needed to layoff or furlough clinicians or staff. This marks an improvement from the [end of May](#), when 14% of practices were temporarily closed, 1% were permanently closed, and 56% had a significant decrease in patient volume. Over a quarter of practices received financial support from the federal government, yet the stress factors persist.

[spending](#). If the state embraced prospective payment, the health care system's foundation, primary care, would be on better financial footing, able to address everyday needs of patients and respond to public health emergencies.

To encourage adoption of prospective payment systems in Texas, lawmakers should:

1. Engage private employers and local governments.

In Texas, 47% of individuals receive health insurance through their employer. [Over the last decade](#), employers' insurance costs rose almost 51%. In 2018, employers paid \$15,159 on average in premiums for a family of four. Moving to prospective payments would reduce costs for companies across the state by improving care coordination and patient outcomes. The same applies to local and municipal governments insuring their employees.

Texas legislators should create a multi-stakeholder working group to implement a voluntary prospective payment model for primary care physicians. The group should include representatives from business groups, state health agencies, private insurers, primary care physicians, and consumers. COVID-19 has taught us lessons and created momentum for reform. While individual insurers and employers can adopt this model on their own, the ability to design and scale a cohesive prospective payment strategy without fear of anti-trust violations is critical. The Legislature should protect this group's freedom to collaborate without fear of antitrust violation by including antitrust protections in statute.

Such collaboration and protection are not unprecedented; a number of other states are already tackling cost, quality and payment reform. In 2011, the Washington State Legislature established the [Dr. Robert Bree Collaborative](#), which created a mechanism in statute for both public and private stakeholders to work together on health care quality, outcomes, and cost effectiveness. Each year, the governor of Washington appoints members to a workgroup representing public and private health care purchasers as well as plans, physicians, and quality improvement organizations. The group identifies areas of high variation in care delivery and cost, and then makes recommendations to the Washington State Health Care Authority to inform the state's purchasing decisions for Medicaid and the Public Employees Benefits Board Program. While the recommendations are nonbinding, the Bree Collaborative is an example of successful collaboration to represent diverse interests. This working group also benefits from antitrust protection and [immunity](#) from federal antitrust laws through the state action doctrine, as granted by the state legislature.

Experts across the political spectrum agree that reforming the way we pay for care to incentivize quality over quantity could contain ballooning health care costs and improve patient outcomes. During the first wave of COVID-19, practices that depended on patient volumes suffered financially. By contrast, physicians operating under prospective payment systems remained viable businesses and nimble in the care they provided their patients during this unprecedented challenge.

Governors across the country are exercising their executive authority to lower health care costs while promoting high-value care. As of February 2020, [21 governors outlined plans](#) to improve health care affordability and quality in their state. In addition to working with the Legislature, Gov. Abbott should establish a workgroup or collaborative to prioritize these issues.

2. Encourage state-funded health plans and Medicaid to implement prospective payment.

Texas should institute a legislative or budgetary directive requiring Texas' Employees' Retirement System and Teachers' Retirement System to offer prospective payment and other alternative payment options to interested primary care physicians and clinics. Collectively, these plans cover more than five million Texans.

Additionally, ERS and TRS should be encouraged to offer some form of direct contracting for primary care services as a benefit option. [New Jersey](#) and [Nebraska](#) recently implemented direct primary care in their state health plans. While the programs are relatively new, both states expect savings and improvements in health outcomes as a result.

Texas Medicaid already requires Medicaid managed care plans to promote value-based payment arrangements, including prospective payments, among network physicians. Small physician practices often struggle to implement such systems because they lack the technical expertise and financial resources. Texas could facilitate broader adoption of alternative payment models among primary care physicians by implementing a monthly per-member, per-month payment to offset upfront costs of practice transformation, better aligning Medicaid performance and outcome measurers with other payers, paying for care coordination and chronic care management, and promoting physician-led accountable care organizations to help organize and support independent physician practices with data analytics, care coordination and other key elements of value-based payment arrangements.

II. MARKET BASED APPROACHES TO DECREASING THE UNINSURED

Relative to the federal government, states have wide latitude to individually test and implement new health care coverage initiatives for their populations, which may in turn demonstrate national applicability. As the second most populous state in the country, Texas has that power in higher measure.

Prior to the pandemic, [18% of Texans lacked health care coverage](#) — twice the national average. However, since February that

number has grown significantly, with an [estimated](#) 660,000 more Texans losing employer-sponsored coverage. Insurance coverage helps individuals [mitigate financial hardship](#) caused by medical needs and expands their access to physicians. Without coverage, many individuals end up in emergency departments for preventable conditions because they avoid or are [unable to access routine medical care](#). Moreover, this population often faces food insecurity and lack of transportation, examples of what are known as social determinants of health — non-medical factors that contribute to poorer health outcomes and higher costs.

Many Texans with health insurance coverage are [underinsured](#) — their out-of-pocket health care costs (excluding premiums) are more than 10% of their income, or 5% for those who are below 200% of the federal poverty level. As such, underinsured individuals often [avoid or delay care due to costs](#).

Finally, Texas is geographically diverse with a significant number of rural communities. For rural Texans, [long distances](#) to urban health care centers limit residents' [access](#) to both primary care and specialists. Similarly, Texans living in urban areas may struggle to obtain primary care when it is not conveniently located close to home or work. Ensuring access to primary care and the coordination of medical care for all these vulnerable populations can help save Texas valuable health care dollars while also improving health outcomes.

With the anticipated renewal of its Medicaid 1115 Transformation waiver, as well as other federal flexibilities to make health care coverage more affordable, opportunities abound to put forward a proposal to the Centers for Medicare and Medicaid Services to test innovative delivery system and payment models to improve access to care for all Texans.

Legislators should consider market-based solutions available to support care for these groups including:

1. Creating a tailored solution to expand Medicaid.

The Medicaid program is an important safety net for low-income adults in Texas. Legislators should reconsider expanding Medicaid under the Affordable Care Act to take advantage of federal incentives and curb the state's climbing uninsured rate due to the COVID-19 pandemic. Expanding Medicaid in Texas would provide [1.5 million](#) low-income working Texans access to health care coverage. At the same time, Texas has considerable flexibility to design a program best suited for its population, including designing the benefit package and establishing patient cost-sharing. Increasingly, policymakers on both sides of the aisle recognize the pressing need to expand health care coverage and support access to care among vulnerable, low-income populations.

2. Pursuing innovative, market-based approaches to reduce the ranks of the uninsured.

Apart from Medicaid, a handful of innovative and market-based approaches could decrease Texans' uninsured rate. Legislators should examine existing programs and consider how the state's [1115 Medicaid Transformation waiver](#) could be used to support vulnerable populations lacking insurance.

Community Accountable Care Organizations

As Texas seeks to renew and reimagine its Medicaid waiver, set to expire in 2022, the state should aim for a community-centric model focused on an inclusive delivery system that fosters participation by physicians, hospitals and other health care providers interested in serving the population. Consider the Community [Accountable Care Organization](#) model, which organizes a varied network of health care providers under a single, community-based board. The model, employed in [Washington](#), Oregon, [Colorado](#), and North Carolina, uses value-based payment approaches to improve population health, a holistic model to address social determinants of health alongside medical issues. Ideally, Texas would implement the model statewide, but a preliminary step could be to pilot select Community ACOs in cities and towns across the state. The Dallas County Medical Society has proposed one city-specific example of a community ACO, the [Dallas Choice Plan](#), which would establish a partnership with the local Parkland Health and Hospital System as a starting point. Legislators could consider this plan as a model to build upon.

Charity Care Programs

Charity-based programs like [Project Access](#) coordinate care for at-risk individuals. Similar programs are proven to improve care and lower spending. Under the Project Access program, a group of physicians and other health care workers [joined forces](#) with program coordinators and community clinics to provide charity care for a set number of vulnerable and low-income patients each year. Patients gained access to a care team who ensured they received follow-up care and assistance with transportation and translation services. These care coordination services lowered hospital costs by 60% compared to similar patients outside the program. Unfortunately, Dallas Medical Society [discontinued Project Access](#) in 2013 due to funding constraints. Legislators should consider reestablishing this program statewide.

Rural Community Health System

In 1997 Texas legislators authorized the [Rural Community Health System](#), establishing a nonprofit insurance entity governed by a community board of rural physicians, hospital administrators, employers and community leaders. By banding together as one insurance entity, these networks could compete against bigger, urban networks, or Medicaid managed care, thus keeping dollars spent on health care within their communities. Legislators should consider this existing framework to support Texans in rural communities.

3. Fostering direct contracting for primary care services.

Texas should foster direct contracting for primary care services through direct primary care. In the DPC model, a physician is paid monthly, quarterly, or annually by an individual or employer to treat all or most of a patient's primary care needs. DPC is [growing](#) in popularity because it prevents unnecessary interventions, promotes transparent pricing, and helps patients better manage their condi-

tions and prevent complications, especially the chronically ill. After implementing DPC through [Iora Health](#), workers in the Las Vegas Culinary Union experienced lower inpatient admissions by 37% and lower health care spending by 12%, compared to control groups outside the practice. Through DPC, Atlantic City hotel workers [reduced](#) their total health care spending by 12.3%. In both Las Vegas and Atlantic City, fewer hospital admissions, emergency room visits, and outpatient procedures explained the considerable savings.

DPC is not considered health insurance and therefore does not enjoy the federal tax advantages of traditional health plans, so cost-effective implementation remains challenging. Because individuals still require emergency or specialty care not offered by a primary care practice, as well as protection from catastrophic health care costs, employers often offer DPC to supplement other insurance plans. A model including DPC must be paired with more affordable coverage options for purchasers to recognize substantial savings. To increase access, Texas should create an avenue to allow for the sale of [catastrophic insurance coverage](#) when offered in combination with DPC. Generally available only to those under 30, Texas could develop a pilot program through a [1332 State Relief and Empowerment Waiver](#) to classify catastrophic coverage purchased in conjunction with DPC as qualifying health coverage for individuals of all ages. The pilot could determine whether this combination structure leads to improved access to care, improved health outcomes, and lower overall costs.

4. Greater regulatory power and data collection to promote a competitive, transparent, consumer-friendly health insurance market.

Texans deserve a competitive health insurance marketplace, and this is possible when the market is transparent and consumer friendly. As consolidation means health care markets become concentrated, research suggests that [prices rise and health outcomes suffer](#). To protect competition, Texas might look to [California](#) where [legislation](#) gives the state Attorney General the authority to regulate mergers among nonprofit health care systems. Furthermore, the California AG is also [seeking greater authority](#) to regulate for-profit health care systems. Texas legislators should empower the state AG with both of these authorities to ensure a competitive marketplace and protect consumers.

Consumers can also enable a more competitive marketplace when they are equipped to shop for care based on price and quality. That is why Texas should work toward a statewide all payer claims database, or APCD, a centralized database that collects medical, pharmacy, and dental claims data from public and private sources. This data is used by researchers and policymakers to identify and launch initiatives to improve quality and health outcomes, while also lowering costs. Among a broader consumer audience, patients can use the APCD to discover how much services cost across physicians, providers, facilities, and locations while shopping for health care.

The largest claims database in Texas is currently the [Center for Health Care Data](#) housed at the University of Texas School of Public Health in Houston, which collects health care utilization data for almost 80% of Texas' population. Today, the data center's capabilities are limited by the volume and type of data that they receive; private insurers are not required to provide the center claims data. To implement a robust APCD, Texas should leverage the existing infrastructure at UT Health and designate the Center for Health Care Data as

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the state's official APCD and require all payers to report claims data. By doing so, the state would empower consumers to actively shop for care in a competitive, transparent marketplace.

III. ACCELERATE THE TRANSITION TO TELEMEDICINE

Once considered a tool to connect rural patients and small physician practices and community clinics with specialists, COVID-19 has demonstrated the broad applicability of telemedicine for both patients and physicians. Texas distinguishes between telemedicine and telehealth. Videoconferences, telephone calls and remote monitoring programs connecting patients and physicians are all considered telehealth. Telemedicine refers to a subset of telehealth that specifically addresses medical care, diagnostic and prescription writing services. Primary care practices that adeptly integrated telemedicine services during the pandemic fared better than those that didn't.

Despite arguments that promoting virtual care could lead to increases in health care use, telemedicine has been shown to [save](#) as much as \$1,500 per visit by keeping patients out of the emergency department. In certain specialties like primary care, increased telemedicine use is [associated with decreases](#) in overall health care spending and hospitalizations.

Historically, virtual care models for payment and use [vary widely](#) across the country, and even within state lines. The COVID-19 pandemic transformed the telemedicine landscape, with public payers and private health plans [expanding](#) covered services and allowing for payment [parity](#) between in-person and virtual visits. The market research firm [Arizton](#) projects that the telehealth market will experience 80% year-over-year growth due to COVID-19. A [survey by FTI consulting](#) finds that this trend is unlikely to reverse, with 51% of Americans reporting they are more likely to use telemedicine options, even after the pandemic subsidies.

COVID-19 led to the adoption of telemedicine at an incredible pace, but it also exposed shortfalls of its predominantly fee-for-service payment system and demonstrated that telemedicine works best when provided in the context of an existing patient-physician relationship. Under these circumstances, physicians and patients were able to transition seamlessly into a new care modality, in many cases made possible by the flexibility provided under a prospective payment model. Many recent reforms to telemedicine payment and coverage remain temporary. Lawmakers must take steps to ensure ongoing telemedicine access in Texas after the present public health emergency subsidies.

As noted above, prospective payments give physicians the flexibility to transition to new care modalities like telemedicine without upending their business operations. Physicians engaged in alternative payment models prior to the public health emergency were able to overcome initial financial stresses caused by the pandemic. According to a [Premier Inc. survey](#), 82% of alternative payment model participants were able to leverage care management supports to manage their COVID-19 patients while only 51% of those in fee for service were able to do the same. Payment policies, like prospective payments for primary care, help physicians focus on caring for their patients without anxiety over reimbursement for a particular modality.

Texas legislators should act to implement and push for prospective payments for interested primary care physicians and practices. Legislators should:

- 1. Adopt Medicare's telehealth flexibilities for consistency and alignment to ease administrative burden for practices.**

Many physicians treat patients covered by various insurance plans, and do not differentiate between sources of coverage when working to care for their patients. When ERISA, commercial or state-based plans do not align with the nation's largest payer, Medicare, physicians spend precious hours pursuing reimbursement from different payers. During COVID-19, many payers aligned their policies with Medicare, which helped ease administrative burdens on physicians. Current policies should be made permanent, like the allowance for patients to receive telehealth services in their home; coverage and payment parity for telephone evaluation and management services; coverage of e-visits and virtual check-ins; and documentation flexibilities that mirror the 2021 Medicare changes, which allow physicians to classify visits based on total time or medical decision-making.

- 2. Adopt telehealth policies that are integrated into a patient's usual source of primary care, rather than restricting telehealth access to designated telehealth partners.**

[Research](#) shows that patients with regular access to their primary care physician have lower overall health care costs and improved health outcomes. Telehealth can enhance the doctor-patient relationship and improve patient and physician satisfaction. Physicians can grow familiar with patients when seeing them in a home setting, learning information unavailable during an in-person visit. When telehealth services are provided by physicians lacking a relationship with a patient, such as through a third-party

platform, those benefits are lost. Texas should encourage payers to adopt telehealth policies that support established relationships between a patient and their primary care physician ensuring continuity of care.

3. Recognize that telehealth is a part of many methods to deliver care, not a standalone modality.

Telemedicine is not just a point of care solution; it is one tool in a toolbox available to providers to help patients maintain and improve their health. It is an excellent option to deliver care, but it should not be the only source of communication between patients and physicians with an existing relationship. The success of virtual care can vary based on a patient's personal needs, something their primary care physician is best fit to assess. Texas should discourage telehealth-only benefit plans, which eliminate a crucial component of care. Instead, payers should alter payment structures to incentivize continuous coordinated care.

IV. RECALIBRATE AND OPTIMIZE TEXAS' PHYSICIAN WORKFORCE

When the ranks of primary care physicians [increase](#), mortality rates from heart disease and cancer, fall, along with [overall health care costs](#). Additionally, primary care-based [coordination of care](#) keeps patients out of costlier settings, like the emergency room.

Unfortunately, the U.S. suffers from a shortage of primary care physicians, and demand outpaces supply. Texas is on track to experience a [shortage](#) of 7,442 primary care physicians (family medicine, general internal medicine, OB-GYN, and pediatrics) by 2032, with 128 counties [designated as full Primary Care Health Professional Shortage Areas](#), and 14 as [partial HPSAs](#). The solution lies in vital programs encouraging medical school graduates and other health care professionals to work in primary care and underserved areas. To strengthen the primary care workforce in Texas, legislators should:

1. Increase opportunities for participation in the Physician Education Loan Repayment Program.

In 2009, the Texas Legislature enhanced the state's Physician Education Loan Repayment Program by changing the way smokeless tobacco is taxed. Legislators dedicated a portion of that tax revenue toward paying off the debt of new medical school graduates who went to work in underserved Texas communities.

According to the Association of American Medical Colleges, 76% of medical students graduate with debt. In the U.S., the average cost for four years at a public medical school is \$243,902. For private medical schools, the cost is \$322,767. According to an [AAMC 2019 survey](#), of the medical school graduates who borrowed money to fund their education, 53.5% borrowed between \$150,000 - \$299,000, a level of debt that preempts many graduates from working in the communities where they are needed most.

Under the PELRP plan, in exchange for a commitment to practice for four years in a HPSA and to participate in Medicaid and the Children's Health Insurance Program, physicians are eligible to receive up to \$180,000 to pay off their educational debt. In the past five years, 775 physicians have enrolled in the program and today care for patients in rural and urban communities, federally qualified health centers and other health care deserts.

And yet, despite the PELRP program's success, the Legislature

has diverted funding from the program and limited participation. Instead, the Legislature should increase funding, maximize participation in the program, and renew its commitment to increase access to care for Texans in rural and underserved communities.

2. Support recent expansion in family medicine residency training by appropriately funding the Family Practice Residency Program.

Texas operates 36 nationally accredited family medicine residency programs, which train the next generation of family physicians. A combination of federal and state monies sustains these programs, which have been funded for decades through the Texas Higher Education Coordinating Board. Although many of these programs receive some benefit from federal Direct Graduate Medical Education and through their sponsoring institutions, dedicated Coordinating Board funds are the only direct state support they receive.

In 2017, the Texas State Legislature cut the Family Practice Residency Program, or FPRP, by 40%, reducing its annual budget to just \$5 million. With the passage of Senate Bill 18 in 2015, the Legislature expanded residency training capacity, including five new family medicine residency programs. While commendable, the expansion, coupled with funding cuts in 2017, thinned FPRP per-resident funding even more. In 2017, the FPRP provided residency programs with \$10,728 for each of the 761 family medicine residents in training. In 2021, it will provide only \$5,485 per resident for 874 family medicine residents.

This program works. The most recent [Texas Higher Education Coordinating Board Budget Strategy](#) notes that 70% of family physicians who complete their residency in Texas practice in the state. The Legislature should increase funding to the Family Practice Residency Program to the annual level of at least \$10,000 per resident.

3. Support physician-led, advanced care team models

The COVID-19 pandemic has demonstrated the success of multidisciplinary, integrated and team-based care. Advanced care team models improve patient care and population health by redistributing clinical and administrative functions, enhancing patient engagement, improving collaboration, and streamlining processes. The model reinforces an interdependent, team-based approach, and empowers non-physician staff to use their skills, training, and abilities. The evidence is compelling. Practices report benefits including increased productivity and capacity to accept new patients, improved performance on quality measures and increased patient and staff satisfaction.

When Texas emerges from COVID-19, the state's policymakers should support team-based care and a prospective payment model to foster more advanced team-based care models to increase access to high quality, efficient care.

V. SPOT THE NEXT PANDEMIC: LEVERAGE PRIMARY CARE FOR FRONT-LINE SURVEILLANCE

When the pandemic hit the U.S., public health officials recommended officials deploy surveillance to identify when COVID-19 arrived in the country, contact trace the disease to try to contain its spread, and identify the start of community spread of the virus once containment was no longer an option.

Many states and localities, including Texas, still lack the resources necessary to successfully contact trace and track the disease as the economy reopens, which heightens the risk and potential severity of future outbreaks. Chronic underfunding of public health across the U.S. led to this outcome. Over the last 10 years, 56,000 public health positions were cut from state budgets and spending for state public health departments has declined by 16% per capita.

Unfortunately, [surveillance was slow](#) in the U.S. Many states and localities, including Texas, still lack the resources necessary to successfully contact trace and track the disease as the economy reopens, which heightens the risk and potential severity of future outbreaks. Chronic underfunding of public health across the U.S. led to this outcome. Over the last 10 years, 56,000 public health positions were [cut from state budgets](#) and spending for state public health departments has [declined](#) by 16% per capita. Kaiser Health News and the Associated Press investigations [found](#) that budget cuts loom for public departments across the country, despite the pandemic. For example, in [Brazos County, Texas](#), funding constraints may force health officials to restrict the county's mosquito surveillance program, and to cut as many as one-fifth of the health department's staff.

Along with public health funding, the national community health care workforce is also diminishing. Before the onset of COVID-19, [almost half](#) of public health workers in the country had planned to retire or leave their organizations over the course of the next five years. Texas urgently needs to replenish its public health care workforce, and creative solutions are in sight.

Capitalizing on the unique position of primary care physicians and their staff, who already help public health officials track both emerging and existent diseases, can help public health officials mount an effective response to COVID-19. Under normal circumstances, primary care practices should operate as the first line of defense against preventable health conditions. Many of these physicians already partner with federal and local public health systems to monitor the prevalence and spread of infections and chronic illnesses such as influenza or diabetes. Yet, challenges and silos persist regionally and technologically. Better integration is critical.

Lawmakers in Texas can promote public health monitoring by:

- 1. Leverage clinical and administrative staff for case investigation and contact tracing to support larger population health.**

During the COVID-19 pandemic, states are in dire need of case investigators and contact tracers. Public health workers remain crucial to federal and state re-opening efforts and will be needed for months to stop the spread of the virus. Texas actively seeks individuals to work as case investigators and contact tracers and both local and state health departments have identified public health students, medical students, retired physicians, and others to fill these roles. Contact tracers have always been an integral part of public health. They can be trained to connect with community members, assess their medical needs and provide solutions. This role is very similar to population health management programs staffed by community health workers who,

instead of identifying individuals with COVID-19, look for individuals who may have undiagnosed, chronic conditions such as heart disease, diabetes or asthma in members of the public.

Given the crossover between community health workers and contact tracers, Texas could pilot a hybrid approach where workers are recruited and trained simultaneously to do both jobs. Administrative and other ancillary health care staff are well-qualified candidates. During the pandemic, many physicians' offices were forced to furlough staff due to [reductions in in-person visits of as much as 60%](#). These health care workers are still essential to the health system, and those working in primary care practices already interact with individuals in the community daily.

Texas could train furloughed medical workers to be contact tracers during a pandemic, and also to be population health surveillance workers under normal circumstances, operating out of their primary care offices of employment. Payment for these services could be included in a care management fee, like CMS Chronic Care Management Services codes, or included in a global prospective payment. Managing chronic conditions successfully is in the best interest of all payers to prevent higher costs should conditions be left to go undiagnosed or untreated for a long period of time. Outside of Medicare, private payers could consider integrating chronic care or population health surveillance into the services requested under a prospective payment agreement.

- 2. Consolidate Texas' IT infrastructure into one public interoperable health information exchange.**

Texas' network of five [regional health information exchanges](#), or HIEs, were designed to help providers securely share and exchange clinical health information and enable patients to access their health data electronically. HIEs help [improve the quality and efficiency](#) of health care services by reducing errors and unnecessary services while enhancing coordination among health care providers and the government. For example, [Healthcare Access San Antonio](#) became a MACRA Qualified Registry in 2017, allowing providers to more easily report and fulfill Medicare reporting requirements for certain incentive programs. Much of the momentum behind the regional exchanges was spurred by the federal [HITECH program](#), which promoted the adoption of health information technology. As this program evolved over time, and incentives changed, most of these exchanges became privately operated at the expense of statewide coordination and interoperability. Today, of the original 18 HIEs funded by the HITECH program, only five are still functional. The [Texas Health Services Authority](#) operates a public HIE as a public-private partnership and oversees the work of the remaining five HIEs.

Texas should establish one statewide, interoperable, and centralized HIE to connect every component of the health care delivery

system from physicians and hospitals, to social service organizations, to public health tracking programs. The HIE would aggregate information from all the existing systems to decrease administrative burdens across providers, streamline public health reporting and ensure that all patients have one, complete medical record. In addition, a key function of the HIE would be bidirectional information exchange. [ImmTrac2](#), a Texas program, is one example of an exchange that allows patient records to be shared seamlessly between an electronic health record and state HIE and vice versa.

Legislators should incentivize payer and provider participation in this centralized public HIE with understanding that payers could use it alongside the state. Ultimately, the HIE could deliver a higher level of care and more streamlined information sharing to millions of Texans. This HIE should include a centralized disease reporting system. Currently, state and local health departments are responsible for collecting communicable disease data to conduct public health surveillance and lead responses. However, health departments in Texas face data sharing obstacles, which restrict their ability to coordinate. In its 2019 annual report, the Texas Health and Human Services Public Health Funding and Policy Committee [called for a more for a targeted disease reporting system](#) to assist local health departments, or LHDs, and the Texas Department of State Health Services collaborate on disease surveillance.

A centralized, statewide electronic disease reporting system could streamline reporting by providers to LHDs and between LHDs and the state. Texas already reports to the [CDC's National Electronic Disease Surveillance System](#); yet, when physicians and other providers need to report communicable diseases, they are responsible for filling out separate [reporting forms](#) and sending them to the LHD, often via antiquated systems such as the fax machine. For ease of transfer and usability, the shared data's format should be interoperable with DSHS systems. Such a system could prepare Texas for the next public health emergency.

3. Restore funding to the state's Office of Minority Health Statistics and Engagement.

People of color experience higher rates of COVID-19 due in part to higher incidence of underlying health conditions, including [asthma](#), [heart disease](#) and [diabetes](#). To understand how certain medical conditions disproportionately affect minority populations, Texas needs more robust data to give lawmakers a fuller picture. To the detriment of all Texans, statistics about health disparities are routinely underreported or under-investigated, including those related to [COVID-19](#). Data has shown that COVID-19 [hospitalization rates are higher](#) among Native American, Hispanic, and Black individuals when compared to their white counterparts. Health care advocates and legislators in Texas have raised alarms that while Black Americans have been disproportionately impacted by COVID-19, the state has not explored why or to what extent.

Texas once had an office devoted to that work — [the Office of Minority Health Statistics and Engagement](#), which sought to study and address racial inequities in health care. When the office was still

active, its staff used community-based research to identify disparities and fix them. For [example](#), data showed higher rates of encounters with Child Protective Services over medical neglect issues in communities of color. The office engaged local community members and found that transportation and scheduling issues caused the disparity. The problem was addressed and the number of Texas mothers who forwent medical care for their children decreased. The Texas Legislature should re-establish this office to improve access to care for minority populations, provide greater insight into the racial inequities they experience and promote health equity.

CONCLUSION

COVID-19 exposed the ways that our health system fails patients. The pandemic revealed flaws in our payment systems, demonstrated how our rules and regulations inhibit technological progress in health care and highlighted how our public health surveillance system is inadequate to contain the spread of disease. But COVID-19 has also given us a roadmap to repair and rebuild a stronger, more resilient system prepared for future public health crises. The pandemic proves that under the right conditions, high-value care and technological innovation can flourish. We see now how a strong public health and primary care workforce is linchpin to meeting Americans' health care needs.

Texas should not waste this opportunity. This five-point plan paves the way for Texas to reform and improve our health care system. Texas should:

- Lead the way for primary care payment reform by changing the existing transactional fee-for-service model to a prospective payment model that supports continuous, comprehensive, and coordinated care;
- Decrease the rate of uninsured Texans through innovative market-based solutions;
- Enable physicians and other health care providers to continue adapting to the digital age by supporting regulatory and payment changes that ensure appropriate use of telemedicine;
- Ensure that all Texans have access to primary care by aligning state appropriations with Texans' current and future health care needs; and
- Develop effective public health workforce and surveillance capacity through a new kind of community health worker and full integration and interoperability of health care data across all levels of government.

While Texas remains focused on containing the spread of COVID-19, the Legislature and the state executive branch can take bold steps to not only improve our costly, fractured health care system, but also ensure the state emerges from this pandemic stronger and better equipped to fend off the next public health crisis. Texas has the resources and leadership to build a better future for its citizens. It is time to lay the foundation.

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