



August 1, 2022

Admiral Rachel L. Levine, MD
Office of the Assistance Secretary for Health
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Office of the Assistant Secretary for Health (OASH) Primary Health Care Request for Information

Submitted electronically via OASHPrimaryHealthCare@HHS.gov

Dear Admiral Levine,

Trinity Health appreciates the opportunity to comment on the primary health care request for information. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 115,000 colleagues and nearly 26,000 physicians and clinicians caring for diverse communities across 25 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 131 continuing care locations, the second largest PACE program in the country, 125 urgent care locations and many other health and well-being services. Based in Livonia, Michigan, its annual operating revenue is \$20.2 billion with \$1.2 billion returned to its communities in the form of charity care and other community benefit programs.

Trinity Health has 17 Clinically Integrated Networks (CINs) that are accountable for approximately 2 million lives across the country through alternative payment models. Our health care system participates in 14 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes eleven markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. Two of the 14 markets also participate in CPC+. In addition, we have had 33 hospitals participating in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative, and three hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

Importance of Primary Care

Trinity Health has 15 medical groups with 1,324 primary care providers and 4,193 specialty care providers. Primary care is essential to helping individuals stay healthy, preventing disease by identifying risk factors, coordinating and managing care for chronic disease and improving quality of life. A report from the National Academies of Sciences, Engineering, and Medicine (NASEM) published last May concluded that primary care is the only medical discipline where a greater supply produces improvements in population health, longer lives, and

greater health equity.¹ The United States must expand and improve primary care in order to achieve better health outcomes at a lower cost.

To support improvements to primary care we need targeted investment and sustainable primary care models and innovations, while also addressing barriers to access and whole-person care.

1. Successful models or innovations that help achieve the goal state for primary health care.

Alternative payment models

Trinity Health is a strong supporter of accountable care models, as they engage providers to consider the whole person—including clinical needs, patient experience and social influencers of health—by linking payment to the quality and outcomes of services delivered. Trinity Health supports models that focus on primary care.

We note that transitioning to alternative payment models (APMs)/population-based models will help improve primary care; however, capitation itself will not solve existing barriers to improving primary care, including the inadequate reimbursement. Models need to be coupled with up-front and ongoing investments and guardrails to ensure that communities most affected by inequities have access. These payment pathways should include adjustment for health status, risk, social drivers of health and social risk, historic under-investment, and other elements.

Innovations

In addition to alternative payment models, there are multiple innovations in the field that show success:

- Investing in community health workers (CHWs)—community-based work is vital to help patients access primary care as they facilitate connections and greater trust between the community and providers. The work of CHWs is not billable in most cases, so health systems must either pay for these services out of overhead, find grant or donor funds to support the work when possible, or simply forgo the work all together. Creating standardized reimbursement structures and elevating the unique professional roles of CHWs would make it possible to help meet patients' social needs in collaboration with their community partners.

Trinity Health is standardizing annual social needs screening for all patients and building CHW Hubs in each of our local health systems. These hubs are staffed by trained and certified CHWs, collaborating with both clinical care teams and local CBOs to receive referrals for patients with positive social needs screenings and use our cloud-based Community Resource Directory, powered by Findhelp, to meet these needs. We have begun incorporating CHWs into care models for our Medicare Accountable Care Organization (ACO) attributed lives, however, in most places this Medicare-focused approach limits our capacity to focus on patients most likely to have unmet social needs: those on Medicaid (unless the health system has a value-based contract with a Medicaid Managed Care Organization or patients are dually-enrolled in Medicaid) and those who are uninsured (who will not fall into any ACO's population of attributed lives).

- Patient Centered Medical Home (PCMH) Model—the holistic, patient-centered approach has been shown to reduce healthcare costs, improve the delivery of preventative services, and improve care coordination with patients who may have complex chronic disease management needs. Its implementation is expensive; however, some states provide differential Medicaid reimbursement for certified PCMH practices. We

¹ NASEM, "Implementing High-Quality Primary Care", <https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care#sectionPublications>

recommend that HHS incentivize states to provide higher reimbursement levels to PCMH practices to defray the cost of the required infrastructure and incentivize adoption of the model.

- Pharmacy integration in primary care—integration of pharmacy and primary care helps to optimize medication therapy and can remedy a number of issues, including barriers to accessing medications, suboptimal dosing or choices of medication, drug interactions, patient lack of understanding, and other errors. Innovations that expand clinical pharmacy roles, including for medical therapy management, can be beneficial. Trinity Health is working to better integrate ambulatory clinical pharmacists in the care teams for our clinically integrated networks, and we recommend HHS allow for and incentivize state flexibility to better integrate pharmacy in primary care.
- Access to affordable, stable housing—growing evidence shows that housing stability and location can significantly affect health care costs, access and outcomes. Providing access to stable housing and housing supports can improve one's health and reduce health care costs. As an example, within a population of nearly 10,000 people with unstable housing in Oregon, the provision of affordable housing decreased Medicaid expenditures by 12 percent. At the same time, use of outpatient primary care increased by 20 percent and emergency department use declined by 18 percent for this group.²
- Street medicine programs—street medicine programs are mobile units that take primary care services to patients that have barriers accessing care, including those experiencing homelessness. Services include: behavioral health services, vaccinations, health screenings, identifying risks for conditions such as hypertension, diabetes, and cancer, identifying and addressing barriers to accessible health care, and education resources on prevention. Several Trinity Health hospitals have strong street medicine programs, including [Mount Carmel](#) in Ohio, [Mercy Care](#) in Georgia, and [Mercy One](#) in Iowa.
- Integrating Food is Medicine into primary care—Food is Medicine refers to a spectrum of programs, services, and other interventions that recognize the critical link between nutrition and health. These services include the provision of food or tailored food assistance (vouchers for produce, etc.) and link to the health care system. Policymakers, health care providers, and social service organizations have begun to recognize that connecting people with complex health conditions to Food is Medicine interventions is an effective and low-cost strategy to improve health outcomes, decrease utilization of expensive health services, and enhance patient quality of life.³
- Remote Patient Monitoring - Trinity Health at Home (THAH) utilizes Remote Patient Monitoring (RPM) to manage the care needs of patients on Home Health. RPM allows 24/7 communication with a clinician who responds quickly to any changes in the patient's status. The primary care doctor is informed of any changes or updates with their patient. THAH uses RPM without reimbursement through Medicare. The integration of care into the home is an excellent way to connect primary care with the patient through 24/7 monitoring, allowing real-time response to reduce hospitalizations and mitigate decline in function. Remote Patient Monitoring should be billable and included as an add-on to the Home Health episodic visit.

² Housing and Health: An Overview of the literature, Health Affairs 2018 [Housing And Health: An Overview Of The Literature | Health Affairs](#)

³ Center for Health Law and Policy Innovation at Harvard Law School, "Food is Medicine: Peer-Reviewed Research in the U.S." [Food-is-Medicine Peer-Reviewed-Research-in-the-U.S.1.pdf \(chlpi.org\)](#)

- **Telehealth expansion** – the COVID-19 Public Health Emergency has enabled the Department of Health and Human Services to provide temporary flexibilities to make telehealth services more readily available, relaxing long-existing barriers to providing care through telehealth. These telehealth changes limited patient and provider exposure to COVID-19, preserved personal protective equipment, and improved access to care. In addition, they have allowed patients with chronic conditions critical access to their physicians. The positive experience Trinity Health has had with the increased adaptation and expansion of telehealth across our health system makes it clear telehealth is a critical component for how we provide high quality, patient-centered care moving forward.

2. Barriers to implementing successful models or innovations

Funding

Barriers to models and innovations stem from lack of sustainable funding for initiatives. Many primary care providers are unable to take the risk on a care management model which may or may not lead to savings—it is challenging enough to provide primary care services with current reimbursement. Coupled with this is the lack of up-front investment for providers to set up and implement new models or innovations. Primary care teams need to be supported with resources to allow them to prioritize and proactively address equity within their practices in partnership with the communities they serve and there needs to be more funding for community health workers.

In addition, there are too few primary care providers to ensure everyone has timely access to primary care—this is driven by current reimbursement practices for primary care.

Data sharing/interoperability

To truly get the full value out of primary care, there needs to be interoperability between primary care teams and CBOs. For Trinity Health, technology and data sharing with our community-based partnership is challenging. Many CBOs are not covered by the Health Insurance Portability and Accountability Act (HIPAA) and there is a lack of knowledge of what data can be shared, how it can be shared safely, and who "owns" the data. Many CBOs do not know what HIPAA is and are uncomfortable sharing certain information.

Cultural change and trust

Models and innovations that improve access to primary care require a cultural shift and buy in from both the clinical providers and community social services providers to ensure success. These aren't changes that are easily made and require incentives. In addition, there needs to be trust in the community—patients need to believe there is value in primary care and that they will be respected by providers. In many communities, you can't successfully establish this trust without community-based workers. In addition, primary care teams need to trust that new models and innovations make sense for them financially.

3. Successful strategies to engage communities

Successful strategies to engage communities include multidisciplinary primary care teams, including community health workers, that reflect—and can meet the needs of—diverse populations, with an emphasis on providing high-quality, comprehensive, integrated care to communities that are structurally disadvantaged by discrimination and other social drivers as well as those with complex medical and behavioral health needs.

Further, including the flexibility and mechanisms to incentivize community residents to help with solving issues goes a long way for community engagement (see FQHC model of including community members on boards).

In addition, the following strategies help to successfully engage communities:

- Evidence-based, group-based care models in primary care settings – ie Centering Pregnancy, Diabetes Prevention Program, and Diabetes Self-Management Education, and integrating lifestyle management programs into primary care.
- Transforming Communities Initiative- This program is an innovative funding and technical assistance initiative advancing policy, system and environmental change, coupled with addressing social needs to make measurable progress toward health and racial equity in 10 of Trinity Health's most vulnerable communities. With an investment of \$1.2 million in fiscal year 2022, and a total investment of nearly \$18.5 million now through 2027, Trinity Health launched a second round of the Transforming Communities Initiative.
- Street medicine and mobile medical care programs, such as those outlined above, that reach members of the community with access challenges are essential.
- Providing flexibility for programs around home-based primary care, including Home Bound and congregational care as these programs can be extensions of primary care and address social isolation with a trusted individual

4. Actions HHS may take to advance the health of individuals, families, and communities through strengthened primary health care

Funding

Incentivize primary care providers

We can't address access to primary care without addressing the need to incentivize more providers to practice primary care. HHS should create stronger incentives for encouraging providers in training to choose primary care, such as loan forgiveness programs, and work with states to increase Medicaid primary care payment to at least the level paid by Medicare. In addition, we recommend shifting the balance of residency slots from specialty to primary care to increase the supply of primary care providers.

Innovations and models

Trinity Health supports the Center for Medicare and Medicaid Integration's (CMMI) goal of having all people receive care through an accountable care relationship – either through enhanced primary care or an ACO. The federal government and states should provide upfront investment and incentives for primary care innovations and models. Included in this are incentives to move away from the reliance on fee-for-service reimbursement and create a greater upside for participating in an alternative payment model. For example, the Medicaid ACO program that Mercy Medical Center in Springfield, Massachusetts participates in has incentives through a per member per month payment for community-based supports and flexible spending supports to go even further than traditional community-based organizations. The model includes a requirement to partner with entities outside of health care system.

To alleviate the burden on primary care practices of taking the risk on a care management model which may or may not be successful, it would be helpful for HHS to define specifically care management models that improve outcomes and reduce cost, and then specifically pay for primary care practices to implement those models of care management.

Primary care safety-net provider organizations such as community health centers and rural health clinics rely on federally required payment structures (ie. the prospective payment system and all-inclusive rate) for their continued financial viability. It is critical that future policy protect these tools while supporting these organizations' participation in mutually agreed upon payment models that improve access and quality.

Social influencers of health/community-based organizations

The federal government must also invest in and provide more resources to address social influencers of health, including access to housing and food. Trinity Health recommends HHS work with HUD to expand integrated models of housing and health care and fund initiatives for congregate housing and supportive housing that bring health care on site. The federal government should also incentivize localities to invest in affordable housing.

This work cannot be successful without providing resources and flexibility to reimburse for community-based organizations and community-health workers. We urge HHS to improve incentives and reimbursement for these entities.

Data sharing/interoperability

Trinity Health believes that standardized, accurate and robust data collection should include race/ethnicity, gender identity and sexual orientation, and that these data should be reported and shared between health systems, other clinical providers, public health departments and government for disease prevention, detection and mitigation. We ask CMS to consider adding housing status, written and spoken primary language, and veteran status as additional factors to be included as part of a minimum set of demographic data elements. Trinity Health also supports efforts to expand and standardize collection of demographic factors such as disability and language preference. Further, health care and public health professionals should use a mandated standardized data set that includes data elements such as race/ethnicity, gender identity, and sexual orientation.

Demographic data collection efforts should be based on standardized electronic data definitions and should be available to providers via interoperable health information exchange. As HHS develops potential approaches for collecting demographic data at point of admission, the Department should consider challenges unique to sub-populations of beneficiaries. For instance, we have found it is very challenging to collect demographic information for homeless patients – and that successful collection requires one-on-one discussion, which is time and resource intensive. We also recommend that all demographic information be self-reported to ensure accuracy and to eliminate the potential for any bias on the part of those collecting data.

Trinity Health is working with the Epic EHR vendor and other health system partners to standardize collection of housing status, among other variables, given the well-documented relationship between housing and health outcomes. Trinity Health would welcome the opportunity to share additional information on these efforts with HHS. In addition, we recommend that HHS examine how Medicaid managed care organizations (MCOs) collect demographic data through comprehensive assessments and the applicability of or lessons learned from this approach that could be applied to the Medicare program.

HIPAA

We also urge HHS to release additional clarifying HIPPA guidance and offer educational opportunities for CBOs to ensure fruitful data sharing with health systems. In addition, HHS should address the financial barriers to interoperability between health systems and CBOs—setting up these systems requires CBOs to invest significant resources and bear additional risk, both of which are barriers.

Primary care access

Integration of behavioral health and primary care

Integration of behavioral health and primary care services improves patient care and outcomes. Collaborative, team-based care between behavioral health and primary care providers (PCP) is critical to delivering high-quality, integrated care. More than 80 randomized controlled trials demonstrate that collaborative care models improve outcomes in depression and other physical health conditions such as diabetes and cardiovascular

disease. A behavioral health specialist assists the PCP in treating patients with depression and anxiety in the PCP office. They review patients weekly with a consulting psychiatrist, and work with the patient and PCP to implement medication recommendations (if needed), delivering evidenced based behavioral interventions. A number of Trinity Health sites in Michigan are successfully implementing this model and seeing improved health outcomes and patient/provider satisfaction.

Trinity Health urges HHS to take steps encourage this integration:

- Support increased behavioral health training for PCPs.
- Fund new and existing clinical care models that use a multi-disciplinary team.
- Provide financial incentives, such as upfront care coordination fees, and align quality incentives in clinically integrated networks and across all payers to facilitate integrated care and reduce administrative burden.
- Encourage states and payers to eliminate restrictions on same-day billing for more than one service per day, a barrier to integrated care.

Telehealth

Maintaining the telehealth flexibilities provided during the COVID-19 public health emergency is critical to expanding access to primary care services. HHS should work with Congress and other policymakers to:

- Allow all telehealth visits to be reimbursed when originated within the patient's home
- Allow all Medicare patients access to telehealth, regardless of geographic location.
- Allow clinicians to furnish and bill with parity of payment for in-office visits across all payers and settings.
- Ensure audio-only remains a reimbursable option for physicians to care for patients who do not have audio and visual technology or capability.
- Clarify that the facility component of telehealth offered in a provider-based clinic is eligible for reimbursement.
- Reimburse providers for telehealth services in home health benefits.
- Include attribution to an ACO as evidence of an existing provider/patient relationship.
- Maintain flexibility for remote-patient monitoring and reimburse for this service, including when provided through home health.
- Allow clinicians to be reimbursed for telehealth when seeing new patients or a patient not previously seen at their practice.
- Remove limitations on frequency of services.
- Remote Patient Monitoring should be billable and included as an add-on to the Home Health episodic visit.
- Allow providers to practice across states lines and at the top of their license, including medication prescription and flexibility to allow physicians to treat their patients while in a state where they may be temporarily located.

In addition, HHS should advance policies that ensure access to affordable broadband, technology resources, and telehealth services. Further, HHS can incentivize programs that will help expand access to primary care services in areas where there is limited or no broadband, including initiatives such as the mobile medical units we reference above. Another example are primary care locations that connect patients virtually to a specialist if that particular specialist doesn't practice in the area. One of our facilities in Iowa does this and patients are able to drive to a primary care office and primary care staff collect vitals, medication lists, and then connect the patient with a specialist all from that one site, helping to remove the barrier that lack of broadband access can have on care.

Language services

Communication barriers can adversely affect the quality of care patients receive. These barriers impair discussions between providers and patients on symptoms and treatment and can impede the understanding of and adherence to treatment plans. For example, studies have shown that patients who need an interpreter but do not receive one are less likely to understand the instructions for taking medications, receive information on medication side effects and experience satisfaction with their care. In a study of emergency department utilization, patients with communication barriers demonstrated a higher rate of resource utilization and increased ED visit times compared to those proficient in English.⁴ We urge HHS to share best practices for language services and provide funding for: identified best practices, equipment, paying a differential for bilingual staff, and incentivizing people to become certified interpreters.

Co-pays

Personal finances impact primary care access and compliance with treatment plans. While waiving co-pays for preventive services has been incredibly helpful, co-pays should also be waived for treatment that prevents hospitalization and readmissions for chronic conditions (ie treatment for diabetes, hypertension, kidney disease). We urge HHS to use its authority to waive co-pays when primary care intervention can prevent exacerbation of a chronic condition.

Conclusion

We appreciate HHS's ongoing efforts to improve primary health care. As you can tell from our responses, Trinity Health is passionate about the care we provide to our communities and are available to partner with HHS to think through new initiatives, join stakeholder groups, or any other conversations around this work. If you have any questions on our comments, please feel free to contact me at jennifer.nading@trinity-health.org.

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health

⁴ Robert Wood Johnson Foundation, "Importance of Language Services"
<https://www.rwjf.org/en/library/research/2008/06/importance-of-language-services.html>