GREATER NEW YORK HOSPITAL ASSOCIATION
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Admiral Rachel L. Levine, MD
Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: GNYHA Comments on HHS Initiative to Strengthen Primary Health Care

Dear Admiral Levine:

Greater New York Hospital Association (GNYHA) is pleased to provide comments for the US Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health's (OASH) Request for Information: HHS Initiative to Strengthen Primary Health Care, which was published in the *Federal Register* on June 27, 2022 (87 FR 38168).

GNYHA is a trade organization representing more than 160 hospitals and health systems across New York, New Jersey, Connecticut, and Rhode Island. GNYHA members provided more than 18 million primary care services in 2019[1] and more than 15 million primary care visits in 2020[2] (the decrease is attributable to the COVID-19 pandemic). According to 2020 Medicare cost reports, the payer mix for these visits was 35% Medicaid, 29% Medicare, 26% commercial, and 8% uninsured. Many GNYHA member hospitals are safety net hospitals, serving mostly patients with public insurance, and all GNYHA members serve people living in communities that disproportionately experience negative health outcomes. Many patients served by GNYHA member hospitals have social needs such as food and housing insecurity and transportation challenges due to the socioeconomic conditions in which they live.

GNYHA member hospitals are committed to providing the highest quality care to all patients, and have demonstrated this through innovations in primary care, strong quality outcomes, and community outreach efforts. GNYHA is pleased to share these experiences, barriers, and opportunities to support the HHS Initiative to Strengthen Primary Health Care.

1. Successful Models or Innovations to Strengthen Primary Health Care

Patient-Centered Medical Home Incentives

New York's Medicaid program has a financial incentive for primary care practices that adopt the National Committee for Quality Assurance's (NCQA) patient-centered medical home (PCMH) model. The New

[1] 2019 Medicare cost report.
[2] 2020 Medicare cost report.

York State Department of Health (DOH) required PCMH adoption in its most recent Section 1115 Medicaid waiver, the Delivery System Reform Incentive Payment (DSRIP) program, which ran from 2014 to 2020. In late 2015, DOH aligned its primary care priorities with NCQA's PCMH model, creating the New York State PCMH program and a statewide advanced primary care standard. New York is a national leader in ensuring access to high-quality primary care for its Medicaid consumers. As a result, New York has 2,399 PCMH-recognized practices, more than any other state, and 21% of the country's PCMH practices.

The financial incentive, which is a Medicaid per-visit payment and a Medicaid managed care per-member per-month increase, has been instrumental in guiding primary care practices toward improvement and transformation. The increased reimbursement has provided hospital-based primary care practices, particularly those in safety net hospitals, with the additional resources to hire patient navigators and other practice support staff, who provide important care coordination and outreach services, allowing providers and other licensed team members to work at the top of their license.

Telehealth Expansion

The COVID-19 pandemic spurred rapid scaling of the telehealth infrastructure in hospital-based practices and a concurrent increase in telehealth visits. Some GNYHA member hospitals reported that part of 2020, telehealth comprised upward of 70% of patient visits. While GNYHA member hospitals now report a smaller percentage of telehealth visits, the modality is expected to remain a vital component of ambulatory care delivery. Telehealth options are helpful for people with transportation challenges or limited time due to personal, professional, and childcare responsibilities. Importantly, hospitals have noted a significant decrease in "no shows" for telehealth appointments, which means community members are more likely to get timely care without their conditions potentially deteriorating because of delays.

While telehealth has alleviated some access challenges, the "digital divide" requires primary care practices to ensure that patients to have telephones, internet, or data plan access to support those visits. Beyond the infrastructure requirements, primary care practices must ensure that patients feel comfortable accessing care with those technologies. Some GNYHA member hospitals have hired telehealth navigators, partnered with community-based organizations (CBOs), and trained administrative staff to educate patients and decrease telehealth barriers. At the same time, GNYHA member hospitals are working to ensure that patients continue to have access to in-person care if that is their preference.

GNYHA recently published a telehealth curriculum guide[3] to help current and future workforce members support telehealth delivery. The guide includes learning objectives, teaching tools, and training resources on telehealth fundamentals, roles and responsibilities in telehealth delivery, and addressing patient access to telehealth services. The guide is available on the GNYHA website and also the Resource Library of the Northeast Telehealth Resource Center, one of the 14 telehealth resource centers funded by the US Health Resources and Services Administration, to reach a broader audience.

Specialty Access

Primary health care delivery is significantly impacted by access to specialty services, many of which are based in hospitals. In recognition of this connection, some GNYHA hospitals have adopted new technology

[3] "Supporting Telehealth Delivery: A Curriculum Guide." GNYHA. (2022). Retrieved from: https://www.gnyha.org/tool/supporting-telehealth-care-delivery-a-curriculum-guide/.

and workflows to increase appointment availability and ensure that patients receive appointments in a timely manner that aligns with the urgency of their medical needs. GNYHA has been working with a cohort of its hospital members to implement a communications tool called an "enhanced referral." This tool prompts primary care providers to share specific information when referring patients and ensures that specialists have the details needed to conduct a thorough and efficient initial visit.

Some GNYHA hospitals have also implemented or are exploring electronic consultations (eConsults), which are provider-to-provider communications that take place outside of a patient visit regarding a specific clinical issue. When clinically appropriate, eConsults can reduce the need for specialty appointments while still addressing the patient's need and helping ensure appointment availability for complex or more urgent needs. Additionally, models that combine eConsults and enhanced referrals have demonstrated health care savings, improved outcomes and access, and increased provider satisfaction.[4,5,6] Improving access to ambulatory care specialties helps ensure that patients receive care in a timely manner and in the most appropriate setting. GNYHA will continue to work with its member hospitals to use these technologies and strategies to ensure that patients receive the right care from the right provider in the timeliest manner possible.

Social Needs Screening and Referral

To help patients and communities, many GNYHA members screen patients for social needs as part of the primary care visit. These screenings identify needs—such as lack of affordable housing and healthy foods, economic insecurity, and environmental safety—inform care plans, and refer patients to CBOs that can alleviate some of their needs. Many GNYHA hospitals are working toward using data collected from social needs screening tools to inform their community health needs assessments, community service plans, and advocacy around community resources. Hospitals also regularly partner with CBOs to provide co-located services, determine eligibility for government benefit programs, and access social services in the community.

Many of the partnerships between hospitals and the CBO community were developed and formalized as part of New York's recent DSRIP program. New York is seeking to build on those practices within its new Section 1115 waiver funding application to the Centers for Medicare & Medicaid Services (CMS) to further strengthen connections between the health care and CBO communities.

Data Sharing

Having key information about the communities and individuals served is necessary to provide whole-person care. Providers having timely access to patient-level and aggregated claims, encounters, and pharmacy data is essential to achieving that understanding. The New York State Office of Mental Health developed a Health Insurance Portability and Accountability Act-compliant data platform, the Psychiatric Services and

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[4] "Evaluation of the Health Care Innovation Awards, Round 2: Final Report." Mathematica. (2020). Retrieved from: https://innovation.cms.gov/data-and-reports/2020/hcia2-round-2-final-eval-report-sept-2020-0.

[5] I. Bhavsar, Wang J., Burke S.M., Dowdell K., Hays R.A., Intagliata N.M. "Electronic Consultations to Hepatologists Reduce Wait Time for Visits, Improve Communication, and Result in Cost Savings." *Hepatol Communications* vol. 3, no. 9 (July 10, 2019); 1177-1182.

[6] S.A. Deeds, Dowdell K.J., Chew L.D., Ackerman S.L. "Implementing an Opt-in eConsult Program at Seven Academic Medical Centers: a Qualitative Analysis of Primary Care Provider Experiences." *Journal of General Internal Medicine* vol. 34m, no. 8 (August 2019);1427-1433.

Clinical Knowledge Enhancement System (PSYCKES), which providers can use as a point-of-care tool to support clinical decision-making and prescribing and to identify other providers that the patient may see. The PSYCKES platform also has reporting capabilities, allowing population health and quality improvement professionals at GNYHA member hospitals to view individual, community-level, regional, and statewide reports to inform new initiatives, partnerships, and other improvement opportunities. While PSYCKES only contains Medicaid and Medicaid managed care claims for individuals with a behavioral health or substance use diagnosis, it is innovative, has powerful use-cases, and if replicated across payers or health information exchanges could broadly support primary care-based population health efforts.

2. Barriers to Implementing Successful Models or Innovations

Payment Models Don't Adequately Support Navigation and Other Non-Clinical Activities

PCMH and other advanced primary care models prioritize activities such as navigation, education, and community service referrals. To ensure that physicians practice at the top of their license, other members of the primary care team should conduct these activities. Unfortunately, these activities are not reimbursable in fee-for-service payment models. Also, value-based payment (VBP) and shared savings models typically do not provide adequate incentives or bonus payments to support the staff needed to conduct these activities. Recently, there has been a significant focus on the important contributions that can be made by community health workers (CHWs), who GNYHA members consider an important part of the health care continuum. However, without adequate reimbursement to support the activities of CHWs, this work will continue to be funded via government grants and philanthropy, which are not reliable or sustainable funding sources.

Similarly, it is difficult for safety net providers to participate in VBP models due to the upfront investments required for necessary workforce, trainings, data platforms, analytics, and operational changes. As incentive payments and shared savings are not guaranteed through VBP models, the financial risk is too great for most safety net hospitals. GNYHA is pleased to see that CMS is seeking to address these and other barriers in its fiscal year 2023 outpatient prospective payment system and physician fee schedule proposed rules.

Limited Access to Actionable and Timely Claims Data

Most health care providers do not have easy access to actionable claims data for their entire patient population. While health information exchanges contain clinical information that can be used at the point of care or for pre-visit planning, most primary care providers lack access to the data and reporting platforms that can help them identify high- and rising-risk patients, usage patterns, and other trends relevant to population health. If primary care providers are to be accountable for overall health and wellness, they must have visibility into patient encounters and claims across the health care continuum. They must also have the tools and resources to analyze and understand the data, which can help identify opportunities for improvement and partnerships and drive decision-making.

Challenges with Standardized Social Needs Data

Many GNYHA member hospitals are using "z codes" to capture information on social risk factors. The ICD-10 manual designates that "z codes" be used for "persons with potential health hazards related to socioeconomic and psychosocial circumstances." Despite the promise of these codes, using them effectively is difficult. One key challenge is that not all common social conditions are included in the available codes. For example, there are no "z codes" to indicate a lack of transportation. Additionally, commonly asked questions in screening tools do not always clearly translate to a specific code.

Another challenge is that the usual workflow for screening and addressing social risk factors does not lend itself to successfully integrated documentation. This is particularly true for the ambulatory care setting, where practitioners handle the coding and not trained professional coders. For example, during a visit, a medical assistant, a nurse, and a doctor each could see a patient. These activities would be documented in the visit note and then finalized and coded by the doctor before the visit is closed. Social worker or care manager encounters, where patients are more likely to engage in robust discussion about social risk factors, are often separate and are documented in a separate note. In most ambulatory care settings, the social work encounter is not billable and would not generate an ICD-10 code, including a "z code." This means that for a "z code" to be included on an outpatient claim, the practitioner would need to be apprised of the separate encounter and record it in the "main" note. This complexity makes the consistent capturing of "z codes" difficult. GNYHA members continue to discuss these issues and work on operational and communication workflows to capture the necessary information accurately and consistently.

3. Successful Strategies to Engage Communities

Use Lessons Learned from the COVID-19 Response

Lessons learned from New York's COVID-19 response can be applied in primary care settings seeking to engage communities. Specifically, getting COVID-19 vaccines into disproportionately affected communities required partnerships with CBOs and faith-based organizations. This was particularly important in communities with reduced vaccine coverage due to misinformation and deep-seated mistrust of both the government and health care system. CBOs and faith-based organizations across New York held outreach days, informational sessions, fairs, and other events that featured trusted health care and public health leaders from their communities and co-located vaccine pop-up sites.

Community-based efforts and other strategies that would help engage communities in primary care efforts are detailed in the Stop the Spread Playbook for Community-Based Vaccinations.[7] The Playbook features efforts led by a federally qualified health center located in New York City and offers strategies for cross-sector partnerships, generating service demand and a framework for health equity initiatives.

4. Proposed HHS Actions

Reimbursement and payment models

To address the payment challenges mentioned above, HHS and CMS should implement a reimbursement methodology that allows for sustained evidence-based initiatives that support community and population health, like the enhanced payments and care management fees developed for the Comprehensive Primary Care (CPC) + model.[8] CPC + demonstrates the importance of multi-payer engagement, and CMS should encourage payers to develop enhanced primary care payments for practices to provide care management, outreach, education, and navigation. These activities require time, resources, and a well-trained workforce. Often small practices and safety net providers cannot afford these resources, which offer slim margins and low reimbursement rates. CMS can address Medicare payments during rulemaking, with a potential timeframe of two years.

Include Specialty Access as a Component of the Primary Care Initiative

Patients commonly require specialty care, and access challenges to outpatient specialties such as gastroenterology, orthopedics, rheumatology, and others are complex. To ensure that specialty access is included in HHS's primary care initiative, it should be an explicit component of the plan to strengthen

[7] https://stop-the-spread.gitbook.io/sts-vaccination-playbook/?utm_source=website&utm_medium=.
[8] "Independent Evaluation of Comprehensive Primary Care Plus: Fourth Annual Report." Mathematica. (May 2022).

primary care. HHS could also leverage the CMS Innovation Center to develop payment models that specifically include incentives for specialty providers to address access challenges and test other models for improving specialty access. GNYHA would welcome opportunities to work with HHS and CMS to develop such an initiative.

Continue Supporting Social Needs Data Standardization

HHS and its agencies support social needs data standardization through ICD-10 updates and participation in the Gravity Project. Over the past several years, the National Center for Health Statistics (NCHS) and CMS have revised ICD-10 to include more specific "z codes" to improve the quality and accuracy of social needs data collected in health care settings. The revisions are based on recommendations from the ICD-10 Coordination and Maintenance Committee Meetings. GNYHA expects the public to recommend additional "z code" changes to further improve data quality and accuracy, such as new codes that map to commonly used social needs screening tools. NCHS and CMS should continue to review these recommendations with the goal of ensuring a robust and accurate set of "z codes."

Additionally, the Agency for Healthcare Research and Quality continues to support the development of national standards for social determinants of health information through its sponsorship and participation in the Gravity Project. The Gravity Project is a public collaborative to advance health and social data standardization that has developed common terminology, interoperability, and data exchange specifications. These tasks have been completed for several social needs, and the work is expected to continue. The Office of the National Coordinator has also included social needs diagnoses and screening codes, terminology, and other definitions developed by the Gravity Project, into standardized value sets to further support social needs data exchange and related interoperability. GNYHA encourages HHS and its agencies to continue this widespread effort.

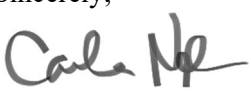
Model Cross-Sector Partnerships

HHS should continue the cross-agency collaboration that took place during the COVID-19 Health Equity Task Force and model the partnerships that hospitals and other health care providers are asked to forge with the human services, education, housing, and other sectors. HHS could create a taskforce that includes representatives from the US Department of Agriculture, US Department of Housing and Urban Development, and the US Department of Education to develop a "health in all policies" approach to ensuring that the resulting negative outcomes of social determinants of health are not solely the responsibility of the health care system. A taskforce can be developed with a potential timeframe of two years, and its recommendations can be implemented over a longer time period.

Contact Information

Thank you for the opportunity to share our comments. Should HHS require additional information, please feel free to contact me (cnelson@gnyha.org).

Sincerely,



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