August 1, 2022

Re: Request for Information (RFI): HHS Initiative to Strengthen Primary Health Care

Dear Assistant Secretary for Health Admiral Rachel Levine,

On behalf of OCHIN, we appreciate the opportunity to respond to the Request for Information to Strengthen Primary Health Care. OCHIN is a national nonprofit health IT innovation and research network with over two decades of experience transforming health care delivery among underserved communities. OCHIN provides leading-edge technology, data analytics, research, health IT workforce training and development, technical assistance and additional support services to more than 1,000 locally controlled community health care sites, reaching more than 6 million patients in 45 states and supporting more than 21,000 providers. Fifty percent of our network’s members’ patients are covered by Medicaid.

OCHIN would like to work with your office to provide HHS with primary care data, including Medicaid related data, timely evaluation, policy insights, and research that bring to light the opportunities to improve primary care access, patient experience and outcomes, as well as primary care sustainability in the most resource challenged communities across the nation.

OCHIN: DRIVING EQUITY

The OCHIN network is comprised of federally qualified health centers (FQHCs) and other community health centers, local public health departments, rural hospitals, school-based clinics, correctional facilities, behavioral health providers, Tribal community providers, and critical access hospitals. In the OCHIN network, among our members’ patients one out of three prefer care in language other than English, and three out of five network patients have chronic conditions. In addition, OCHIN leads the ADVANCE Clinical Research Network (CRN), the nation’s largest safety net community laboratory. The goal of ADVANCE is to build and maintain a “community laboratory” of FQHCs serving safety net patients, including individuals covered by Medicaid, the uninsured, the under-insured, undocumented immigrants, and other populations that face persistent structural inequality.

Strengthening primary care requires ongoing investments in technological modernization as well as innovative and flexible workforce development and training programs to increase capacity in the face of demographic shifts and persistent structural inequality in health care. (Physician and nurse shortages have only deepened during the COVID-19 public health emergency which is unlikely to be reversed as the U.S. Census Bureau projects that by 2030 one in every five Americans will be retirement age.) Innovation to drive health equity has been OCHIN’s mission for decades. It is complex, requires systems thinking, user-centered and equity by design methods, as well as the trust of the communities served. Based on these learnings OCHIN is committed to transforming care by:

- Supporting more seamless care through a broader more cohesive system of care by building systems and advancing policies and practices to overcome costly and complicated fragmentation.
- Producing robust and usable data driven, evidence-based insights to improve health outcomes that allows the unseen to be seen in underserved communities.
• Facilitating adaption to changing times through collaborative-based solutions and policies to connect to patients (including the hardest to reach), reduce risk, manage compliance, and accelerate innovation.
• Integrating digital tools and solutions to help close health disparities and virtual care modalities (like telehealth) to connect more to care.
• Increasing ease and efficiency through clear workflows in critical areas with the training and support to implement and use while reducing administrative and regulatory burdens faced by providers and their patients.

OCHIN RECOMMENDATIONS

The following are recommendations to strengthen primary care, particularly among providers in communities that face structural inequality and health disparities:

1. **Promote Primary Care Sustainability and Reduction in Administrative Burdens as well as Resilient Public Health Capabilities Through National Digital Data Standards and Quality Measures.**

Current data collection and reporting mandated by federal and state health care programs imposes fragmented, duplicative, and costly obligations on primary care providers. As a result, data collection and quality measurement practices, policies, and initiatives continue to obscure structural inequality. OCHIN has been a trailblazer in supporting the development, testing, and use of national social determinant of health and demographic digital data standards and quality measures. For example, over 1 million EHR documented social determinant of health screenings have been completed by OCHIN network members. OCHIN is able to provide cross-state Medicaid program comparisons that account for SDOH as well as demographics including sexual orientation and gender identity. At scale, it is not possible to improve outcomes, strengthen public health capabilities, and understand the total cost of care among primary care providers in underserved communities without this essential information. It is challenging to fix what you cannot quantify and measure. **We urge the Administration to prioritize funding for national digital data standards development needed to identify and scale equity in health care and public health, undertake technical testing among providers that serve a high percentage of patients covered by Medicaid/CHIP, and support technical assistance and training for underserved communities and their primary care providers. In the interim, OCHIN welcomes sharing with CMS standardized data across state Medicaid and CHIP programs collected by our network members that would inform the Administration’s efforts to strengthen primary care equitably.**

2. **New Medicaid and CHIP Payment and Delivery Models Are Needed that Reduce Administrative Burdens and Reflect Whole Patient Care While Driving Value.**

The current primary care payment methods, particularly Medicaid and CHIP, are not meeting the operational costs of providing care to patients who face structural inequality and have higher clinical complexity. OCHIN has produced an analysis of the significant role that the 340B prescription drug program (340B) plays in covering current operating costs for covered entities in the OCHIN network. For the sampled members, the level of 340B funding is significant, making the difference between operating at a net gain or loss for the majority. As practices by pharmaceutical companies and pharmaceutical benefit managers continue to reduce this funding, it directly undermines the sustainability of primary providers like those in the OCHIN network that serve a high percentage of patients with Medicaid and CHIP coverage. Failure to replace 340B net revenue could result in closure of many of the nation’s community health clinics with devastating impact on patient care. **In addition, current fee-for-service and new value-based models do not adequately account for the social determinants of health that impact outcomes of patients nor do payment models include standardized social determinant of health quality**
measures. As a result, primary care providers with a high percentage of patients covered by Medicaid and CHIP (as well as Medicare) are increasingly being urged or directed to accept levels of risk that have not been adequately quantified nor understood. These models do not align payment so that interventions are sustainably integrated to produce improved outcomes that bend the cost curve and begin to dismantle structural inequality. OCHIN strongly urges the Biden Administration to fund, in partnership with OCHIN and other stakeholders, the acceleration of development and testing a full range of payment models and quality measures as well as equity quotients that can accurately account for risk while ensuring the 340B program is strengthened.

3. Urge States and other Federal Agencies to Prioritize Health IT Professional Development and Training for Operational and Support Staff Who Are Essential to Meeting Existing Need as Well as to Support New Value-Based Models.

The deployment of telehealth and other virtual modalities along with modernized health IT systems can streamline and strengthen care delivery in primary care practice, but this cannot occur for practices that do not have operational and support staff who are able to deploy, maintain, and optimize use of new systems throughout the health care and social service ecosystem. There are existing and growing shortages of such staff among OCHIN network members. In addition, these shortages negatively impact the capacity of primary care providers to provide access to clinical services, support public health readiness, and transition to new payment and delivery models such as value-based models that require the availability of digital clinical and operational data. We urge the Administration to take immediate steps to target funding to support operational and support staff health IT workforce development and training for community clinics in underserved communities and local public health agencies that serve a high percentage of patients covered by Medicaid and CHIP. Through innovation and experienced staffing, primary care providers can improve the end-to-end experience of the care team (including clinicians suffering high rates of burn out) and patients.


Meeting patients where they are is essential to improving health outcomes, empowering patients, and driving lower overall health costs. Telehealth (including audio-only services) and other digital modalities have proven to be essential tools for overcoming structural inequality during the COVID-19 public health emergency (PHE). We must center care where patients can readily access it. OCHIN has conducted an in-depth analysis of telehealth utilization in California and found that telehealth (including audio-only) was utilized at higher rates by individuals who faced housing and transportation insecurity. Ensuring primary care providers are compensated adequately for virtual modalities without additional coverage limitations and requirements will drive savings, improve outcomes, and mitigate the looming shortages by increasing efficient use of health care through more appropriate sites of care. (See, The Telehealth Era is Just Beginning, by the former CEO of Kaiser Permanente and the current Executive Director of Telehealth Services at Intermountain Healthcare.) We strongly urge the Administration to provide incentives and flexibilities to state Medicaid and CHIP programs, so they permanently extend the COVID-19 PHE coverage and reimbursement parity as well as other flexibilities related to FQHC service areas, authorized practitioner billing, and prescribing. We also urge the Administration to address onerous requirements, such as mandated in-person encounters before or after virtual visits while addressing the cost and burden of credentialing that fall heaviest on providers in underserved communities.

5. Directly Fund Virtual Specialty Network Dedicated to Offering Services in Underserved Communities to Increase Access and Facilitate Transitions to Value-Based Pay that Supports Whole Patient Care Among Primary Care providers.
A persistent challenge that will only deepen due to clinician shortages and demographic trends is lack of access to integrated specialty care for patients with Medicaid and CHIP coverage who are located disproportionately in underserved communities. Primary care providers in underserved communities cannot drive improved outcomes and sustainability without access to timely specialty referrals. OCHIN network data reflects national trends in limited access and delayed referrals to specialists, which drives health disparities in underserved communities and communities of color. In the 2019 analysis, OCHIN found that time to appointment was 44 days on average across patients served and referrals that took longer than 2 months to schedule were 40% less likely to be completed. This reality was documented before the COVID-19 PHE and similar trends have continued during the COVID-19 PHE despite the availability of extensive telehealth flexibilities during the latter. Factors for these delays include specialist shortages, geographic mismatch, lack of transportation and other structural impediments as well as Medicaid and CHIP payment rates that are not competitive with Medicare and commercial health insurers. We urge the Biden Administration to invest in the infrastructure of a virtual specialty care network that partners with existing primary care community-based providers serving a high percentage of Medicaid/CHIP covered patients.

6. Urge States to Direct COVID-19 Infrastructure and other Rescue Funds to 21st Century Health IT for Providers in Underserved Communities Including Behavioral and Mental Health Providers.

Foundationally, to transform delivery of health care, primary care providers and other service organizations must have modernized interoperable and secure health information technology and digital options, particularly those who are serving patients with Medicaid/CHIP coverage. Behavioral health and mental health providers did not receive the same incentives to adopt certified interoperable health IT systems. As a result, there remain challenges with integrating these services and facilitating secure interoperable exchange. We urge the Administration to target already authorized and appropriated COVID-19 rescue and infrastructure funds to health information technology modernization for community clinics, critical access hospitals, behavioral and mental health providers, and local public health agencies that serve a high percentage of Medicaid/CHIP covered patients.

CONCLUSION

We have outlined a range of policies, but there are additional recommendations based on analysis of OCHIN network data that we would welcome sharing with you including the impact of documentation requirements on costs and clinician burn-out. Please contact me at stollj@ochin.org to discuss how OCHIN can support your efforts moving forward.

Sincerely,

Jennifer Stoll
Executive Vice President
External Affairs