BEFORE THE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH, OFFICE OF THE SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Information: HHS Initiative to Strengthen Primary Health Care, 87 FR 38168 (June 15, 2022)
Federal Register No. 2022–13632

Names of Respondents: Transhealth Northampton, Howard Brown Health, Callen-Lorde Community Health Center, Legacy Community Health, and Whitman-Walker Health.

Areas of Response:

1. Successful models or innovations that help achieve the goal state for primary health care
2. Barriers to implementing successful models or innovations
3. Successful strategies to engage communities
4. Proposed HHS actions

Descriptions of Organizations
Please see Appendix A

Contacts: Dallas Ducar, CEO, Transhealth Northampton, dallas@transhealth.org
Tim Wang, Director of Policy and Advocacy, Howard Brown Health, TimothyW@howardbrown.org

COMMENTS OF TRANSHEALTH NORTHAMPTON, HOWARD BROWN HEALTH, CALLEN-LORDE COMMUNITY HEALTH CENTER, LEGACY COMMUNITY HEALTH, AND WHITMAN-WALKER HEALTH

I. Primary Health Care Payment Models Should Include Supportive Services

As noted in the RFI, primary care is vastly underfunded, which stresses our workforce capacity unnecessarily. As FQHCs and look-alikes with medically complex, socially stigmatized, and economically marginalized patient populations, a majority of our supportive or wrap-around services that enable our patients to access primary care services are not reimbursable in existing fee-for-service payment models. The funding streams that allow us to provide non-reimbursable supportive services require immense administrative investment, often through private and public grants. Unreliable program funding impedes our ability to invest in workforce capacity and sustainable growth models. This impacts community resilience negatively and reflects a cycle of chronic underinvestment in marginalized communities.

HHS should continue to advance the transition to value-based care models while increasing the funding for evaluation and quality improvement programs and community-based research projects to seed innovation in health promotion. To advance equity, HHS should also invest in the dissemination and implementation of evidence-based education and training in cultural competency, and trauma-informed and patient-centered primary care. HHS should explore the use of diagnostic

codes related to social determinants of health (SDOH) and care management to facilitate reimbursement of these activities under existing insurance systems. HHS should support research programs to investigate how a system of universal health insurance that funds supportive services can provide the foundation for a strong primary care system that incentivizes investment in SDOH.

Also, HHS should provide additional funding to FQHCs as a strategy to strengthen the safety net. There are a number of funding opportunities HHS can utilize to provide funding to Look-Alikes under Section 330 of the Public Health Law. HHS should consider special circumstances that are not captured in the standard assessment process when considering whether to designate Look-Alikes as 330 eligible entities. This approach is consistent with other instances where HHS has demonstrated flexibility in the funding assessment approach to achieve specific outcomes. Lastly, even without 330 funding, simply designating Look-Alikes as 330 grant-eligible entities would allow them to take advantage of the Federal Torts Claims Act (FTCA) and apply for federal grants that are not available to non-330 grantees at no additional cost to the federal government.

II. FQHCs Innovate Patient-Centered Care Delivery Models

Ideally, community health centers are enabling environments for health that support access to medical services and the SDOH. For example, in a patient-centered care approach, FQHCs with attached medical-legal partnerships help address the health-harming legal needs of patients and clients. Co-locating services within the health center supports access to both primary care and related health-promoting programs. Similarly, innovative delivery models that dramatically lower barriers to care, like Red Carpet services and Rapid Start models for people living with HIV or at risk for HIV acquisition, support engagement with primary care. The treatment and prevention of many chronic diseases, like diabetes, hypertension, asthma, and COPD may benefit from techniques to maximize the opportunity to address a patient's needs while they are present at the health center.

III. Service Integration Requires Supportive Care Coordination Professionals

Integrated care models foster whole-person care through collaboration between primary care, behavioral health, oral health, public health, and social services. Research has shown that integrated or collaborative care models improve clinical outcomes for patients, especially those living with chronic illness and mental health burden.[1] Integrated care models within FQHCs in particular have resulted in increased access to care, reduced stigma, and improved patient satisfaction and health outcomes.[2]

The members of the LGBTQIA+ Primary Care Alliance have certainly found this to be the case, especially for our LGBTQ+ patients who often experience discrimination and barriers. For example, at Howard Brown Health in Chicago, trans and non-binary (TNB) patients are able to access gender-affirming and affordable primary, behavioral, and dental care, pharmacy and surgical navigation services, and case management for needed social services under one roof. Given the recent surge in state legislation targeting access to affirming health care, providing accessible affirming care is more important now than ever.

Financial barriers, including a lack of significant workforce investment and the underfunding of and lack of reimbursement for critical services, often prevent the implementation of integrated care models. FQHCs rely on community health workers (CHWs), patient navigators, and case managers to

ensure integrated care. CHWs and patient navigators are low-cost team members who are integral to delivering whole-person care.[3] They improve access to health care and social services, and improve health outcomes among underserved communities, particularly in populations with chronic disease, people living with HIV, and members of the LGBTQ+ community.[4] HHS could improve uptake and implementation of integrated care within primary care systems by providing adequate funding and financial incentives—including funding and reimbursement for care coordination professionals.

IV. Civil Rights Protections Facilitate Access for Priority Populations

A stable, strong primary care system must be accessible and acceptable to all. For our priority populations, creating accessible health centers requires: culturally competent staff and providers, welcoming and affirming language to LGBTQ+ people, and centrally located health centers with accessible architecture that communicates respect and dignity.

Since the passage of the Affordable Care Act, the United States has made significant progress in making care accessible, both financially through subsidies, linguistically through requirements around language access, and through the anti-discrimination requirements of § 1557 providing protections for historically underserved minorities. HHS should continue to improve access to primary care by removing barriers for priority populations, for example ending the requirement for mental health diagnosis to access gender-affirming hormone therapies and switching to an informed consent model.[5][6][7] HHS should research the feasibility of substantially expanding the care that is available without cost-sharing.

V. Streamline Education and Reduce Administrative Burden of Practicing Medicine

To support a strong primary care system more health care professionals are needed in the workforce. HHS should support efforts to reduce sources of strain for health care professionals, which also present opportunities to reduce the cost of our primary care system and support the next generation of health care professionals. HHS should support programs to make education for health care workers available without cost. Additionally, health care workforce education should be easy to enter, with flexible training and opportunities for continuing education and advancement. HHS should identify how overlapping federal and state regulatory requirements can be streamlined to facilitate resilience and flexibility in the health care workforce. HHS should support innovations that reduce the administrative burden of health insurance systems. To support a primary care system that addresses the needs of LGBTQIA+ people, HHS should address the gaps in education on their health care needs, and support and promote practitioners and researchers from marginalized backgrounds, including through grants, loan forgiveness, and educational and outreach programs.

VI. Support Increased Interstate Practice and SOGI Inclusive Data Collection

Telehealth expands access to primary care for rural communities and access to mental healthcare for our priority populations.[8] To support the expansion of telehealth, HHS should support policies that enable interstate practice. The COVID-19 pandemic has demonstrated the need for the continued and expanded use of telehealth to reach rural and underserved populations. Parity in payment between telehealth and in-person health appointments would incentivize clinicians to

provide this service. While some states have laws about telehealth parity, a national intervention would ensure access to all people, regardless of what state they live in.

Support for expanding the use of electronic medical records (EMRs) has been an ongoing HHS priority and we encourage HHS to continue to incentivize meaningful use in primary care centers. For our priority populations of LGBTQIA+ people, HHS should require EMRs that capture the full breadth of diversity our patients present. This means supporting continued adoption of USCDIv.2, which includes updated SOGI markers and continued research on innovations in EMR interoperability to allow care coordination across care environments.

VII. Conclusion

Respectfully submitted,

Transhealth Northampton, www.transhealth.org
Howard Brown Health, www.howardbrown.org
Callen-Lorde Community Health Center, www.callen-lorde.org
Legacy Community Health, www.legacycommunityhealth.org
Whitman-Walker Health, www.whitman-walker.org

Contacts:
Dallas Ducar, CEO, Transhealth Northampton, dallas@transhealth.org
Tim Wang, Director of Policy and Advocacy, Howard Brown Health, TimothyW@howardbrown.org

August 1, 2022

Endnotes

1. Gerrity M. (May 2016). Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015. Milibank Memorial Fund. Available online at: https://www.milbank.org/wp-content/files/documents/10430EvolvingCare/EvolvingCare.pdf
2. Grazier KL, Smiley ML, Bondalapati KS. Overcoming Barriers to Integrating Behavioral Health and Primary Care Services. *Journal of Primary Care & Community Health*. October 2016:242-248. doi:10.1177/2150131916656455
3. Kangovi, Shreya, et al. "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment." *Health Affairs*, vol. 39, no. 2, 1 Feb. 2020, pp. 207–213, 10.1377/hlthaff.2019.00981.
4. Landers S, Levinson M. Mounting Evidence of the Effectiveness and Versatility of Community Health Workers. Am J Public Health. 2016 Apr;106(4):591-2. doi: 10.2105/AJPH.2016.303099. PMID: 26959254; PMCID: PMC4816154.
5. White Hughto, Jaclyn M., et al. "Barriers to Gender Transition-Related Healthcare: Identifying Underserved
6. Schulz SL. The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria. Journal of Humanistic Psychology. 2018;58(1):72-92.
7. Ibid.
8. Loo, S., Almazan, A. N., Vedilago, V., Stott, B., Reisner, S. L., & Keuroghlian, A. S. (2021). Understanding community member and Health Care Professional Perspectives on gender-affirming care—a qualitative study. *PLOS ONE*, *16*(8).

Appendix A
Descriptions of Organizations

Transhealth Northampton, Northampton, MA

Transhealth Northampton is a groundbreaking independent and comprehensive trans healthcare center built to empower trans and gender-diverse adults, children, and families. Throughout our history as a community, trans and gender-diverse people have looked to each other for healing, support, and affirmation. Transhealth Northampton honors that by providing comprehensive and professional healthcare, as we open our doors to trans and gender-diverse individuals and their loved ones. As a trans-led organization, we are uniquely positioned to expand the healthcare possibilities for our community. Through research, expert care, and fierce advocacy we work to secure a healthy, affirming future for all of us.

Howard Brown Health, Chicago, IL

Rooted in LGBTQ+ liberation, Howard Brown Health provides affirming healthcare and mobilizes for social justice. We are agents of change for individual wellbeing and community empowerment. Howard Brown Health envisions a future where healthcare and transformative social policies actualize human rights and equity for all.

Callen-Lorde Community Health Center, New York, NY

Callen-Lorde Community Health Center is the global leader in LGBTQ health care. Since the days of Stonewall, we have been transforming lives in LGBTQ communities through excellent comprehensive care, provided free of judgment and regardless of ability to pay. In addition, we are continuously pioneering research, advocacy and education to drive positive change around the world, because we believe healthcare is a human right. Callen-Lorde Community Health Center provides sensitive, quality health care and related services targeted to New York's lesbian, gay, bisexual, and transgender communities — in all their diversity — regardless of ability to pay. To further this mission, Callen-Lorde promotes health education and wellness, and advocates for LGBTQ health issues.

Legacy Community Health, Houston, TX

As a full-service, Federally Qualified Health Center, Legacy Community Health Center identifies unmet needs and gaps in health-related services and develops client-centered programs to address those needs. A United Way-affiliated agency since 1990, we currently provide adult primary care, pediatrics, dental care, vision services, behavioral health services, OB/GYN and maternity, vaccinations and immunizations, health promotion and community outreach, wellness and nutrition, and comprehensive HIV/AIDS care.

Whitman-Walker Health, Washington, DC

Whitman-Walker Health is a Federally Qualified Health Center serving greater Washington, DC's diverse urban community, including individuals who face barriers to accessing care, and with a special expertise in HIV care and serving lesbian, gay, bisexual, transgender and questioning/queer

(LGBTQ) populations. In our mission we empower all persons to live healthy, love openly, and achieve equality and inclusion. WWH services include primary medical care, HIV and LGBTQ specialty care, oral health, mental health care, addictions treatment services, psychosocial support, medical nutrition therapy, early intervention services, public benefits and insurance navigation, nurse-focused case management, HIV and STI screening, legal services, youth programs, and an onsite pharmacy. The health center has achieved Level 3 Patient Centered Medical Home accreditation with the National Committee for Quality Assurance.