November 20, 2017

Amy Bassano, Acting Director
Innovation Center
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted Electronically to
CMMI_NewDirection@cms.hhs.gov

Re: Request for Information for the Innovation Center's New Directions

Dear Acting Director Bassano,

Whitman-Walker Health (WWH or Whitman-Walker) is pleased to respond to CMS' Request for Information, "Innovation Center New Direction," issued September 20, 2017, https://innovation.cms.gov/initiatives/direction (RFI).

INTEREST AND EXPERTISE OF WHITMAN-WALKER HEALTH

WWH is a Federally Qualified Health Center located in Washington, DC and serves individuals from across the region. Our care model is the patient-centered medical home, operationalized through an integrated, interdisciplinary team that provides holistic medical, behavioral health, and dental care supported by legal assistance, patient navigation and social support services. Core services include primary and preventive medical care; pharmacy; dental care; mental health care, including psychiatry and substance use counseling (individual and group offerings); treatment adherence and care management; HIV and STI testing and prevention; nutrition counseling; legal services and public benefits and insurance navigation; community health and wellness; clinical and health services delivery research; and medical education and training. WWH serves our patients and the community at large by operating two clinical sites – our health center at 1525 14th Street NW and the Max Robinson Center in Anacostia – and two program sites providing legal, insurance navigation, youth, and administrative services. Our health center team is comprised of more than 270 employees – including more than 50 medical and behavioral health care practitioners – who serve on the front lines of the District of Columbia's health care system and at the crossroads of health care reform.

In calendar year 2016, WWC provided health care services to 16,253 unique individuals – through 120,664 encounters across all programs, or more than 600 encounters per day of operations. Our patients live and work in metro Washington, DC – a region increasingly shaped by diversity and intersectionality. Six in 10 WWH patients are people of color. More than half of our patients report that they identify as lesbian, gay, bisexual or transgender (LGBT). Six in

📞 **202.745.7000**
📍 **www.whitman-walker.org**

Whitman-Walker
1525 14th St., NW
Washington, DC 20005

Max Robinson Center
2301 Martin Luther King Jr. Ave., SE
Washington, DC 20020

Eastern Market
651 Pennsylvania Ave., SE
Washington, DC 20003

10 of our patients report annual income less than 200% of the federal poverty level. One in 5 of our patients – 3,285 individuals – are living with HIV.

Whitman-Walker's payer mix is more diverse than that of a typical FQHC operating in Washington, DC. Nearly 2 in 5 medical patients have commercial insurance. Forty-eight percent are covered by public insurance programs – most under Medicaid (32%) or Medicare (10%).

Whitman-Walker has numerous collaborative agreements with DC-based health care groups and human services organizations. We are actively pursuing affiliation strategies to prepare for managing clinical and financial risk of our patients in the future. Our horizontal integration strategy lies in the development of a clinically integrated network with other DC-based FQHCs and the DC Primary Care Association. Our vertical integration strategy focuses on formal affiliation with an academic health system and/or a health insurer.

<center>RESPONSE TO THE REQUEST FOR INFORMATION</center>

Whitman-Walker Health is happy to share our experience regarding "patient-centered care and market driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes" as requested in this RFI. Specifically, we address the following priority areas identified by CMS: increased participation in Advanced Alternative Payment Models (Model No. 1 in the RFI); state-based and local innovation, including Medicaid-focused models (Model No. 6 in the RFI); and mental and behavioral health integration (Model No. 7 in the RFI).

We also offer a broader view of integrated care by highlighting the role that social determinants of health play in overall health and well-being, and how health care models can and should address these factors.

CMS-Identified Model 1: Increased Participation in Advanced Alternative Payment Models (APMs)

The District of Columbia Medicaid program implemented an Alternative Payment Model (APM) with the FQHCs in DC as of September 1, 2016. The model has different rates by service area: (1) medical; (2) behavioral health – one rate for all services except group, and a separate rate for group services; (3) preventive dental; and (4) restorative/comprehensive dental. In addition, the rate-setting process includes incentive/shared savings for achieving specific performance outcomes. Performance-based payments will apply to claims beginning January 1, 2018, and will be analyzed for payment at the end of 2018.

Based on our experience to date, Whitman-Walker believes that any APM model should be grounded in clearly articulated core values, achievable goals, and defined performance measures/health outcomes. Above all else, any such model must have a single guiding principle or "North Star": *it should be planned, implemented, and financed in a patient-centric manner*. This patient-centric philosophy should inform – and, if necessary, override – any and all specific goals regarding access, quality, and cost/value. Our perspective here is informed by WWH's

experience with FQHC requirements, the Medicaid MCO and fee-for-service programs, and the Medicare fee-for-service program. In all of these programs, WWH providers and administrators endeavor to provide the best possible care that patients require while meeting the complex and oftentimes competing goals and specific requirements of each program regarding access, quality, and cost. We recognize that many of the specific goals and objectives are mandated by CMS, contractually set by Medicaid MCOs, and/or financially driven by the annual budgets of local, state and federal agencies. We recommend that improved health and well-being for consumers/patients be the goal, and that requirements across programs and payers should be streamlined. Whitman-Walker would be happy to provide more information and specific suggestions at any time.

In addition, any APM initiative that seeks to transform the delivery system must allow providers enough time to implement changes to care models. Such initiatives aim, to increase patient engagement, improve health outcomes, and lower health care costs. However, such initiatives – particularly when applied to community health centers that offer integrated care models – may not immediately lower costs. Costs may shift to more appropriate care in the care continuum – for example, patients using primary care and specialty care instead of low-acuity non-emergent ER visits. The goal of lowering health care costs should focus on appropriate use of care – not exclusively on the dollar amount.

One critical component to moving to risk-based care models is appropriate health information technology (HIT). HIT must allow communication across providers' electronic health records and payer data systems as well as data analytics capability. **Currently, providers almost always are forced to navigate several distinct and inconsistent HIT platforms. This is grossly inefficient and not sustainable.**

Another important point is that community health centers such as WWH have little to no control over care provided outside of their own health centers. Whitman-Walker works with our patients to reduce unnecessary ER utilization through nurse triage models and expanding our own hours. However, our patient population disproportionately faces serious chronic care issues. At times, the needs of these patients may exceed our capacity, as WWH is not an urgent care facility. Any APM or value-based payment initiative needs to recognize that health centers and other providers will not have control of the larger health care system, and it is unrealistic and ineffective to impose financial risk and burden on the provider for those aspects of care outside of their influence and control.

To summarize, future innovations intended to expand access and patient engagement, improve quality, promote health equity, and enhance value and efficiency, should:

- embrace a patient-centric philosophy as their guiding principle;
- expand health information technology, data exchange and analytics for greater patient engagement and population health management needs;
- align performance measures and incentives around a core set of health outcomes to drive greater accountability and streamline complex and too-often inconsistent requirements imposed by different programs and providers; and

- ensure that funding follows the patient – when the patient changes providers or is referred to a specialist, payments follow the patient to the new or additional provider to incentivize the care that the patient's needs or wants.

In addition, as explained below (pages 8-10), innovation models should incentivize health care systems to address social determinants of health – for instance, housing, transportation, food security, employment and insurance – in program design, implementation, and financing.

CMS-Identified Model 6: State-Based and Local Innovation, including Medicaid-focused models

The importance of Clinically Integrated Networks (CINs). The cost of healthcare in the United States is outpacing inflation at a significant rate. In 2015, national health care expenditures grew 5.8% to $3.2 trillion, or $9,990 per person, and accounted for 17.8% of GDP with Medicaid expenditures outstripping all other health care spending.[1] Yet this increased spending is not producing better health outcomes.[2] In Washington DC, as in many other areas of the country, the primary insurer of patients accessing care at community health centers is Medicaid. This puts FQHCs in an ideal position to work together with the Medicaid program to reduce unnecessarty costs while improving health outcomes. Care provided in the primary care setting is much less costly than similar care provided in emergency rooms and hospitals. FQHCs have provided primary care services to those with limited access to care for more than 45 years. A disproportionate share of the most vulnerable adults, including those who have low family incomes and those in poor health, receive their care from FQHCs.[3]

Accountable Care Organizations based on a horizontally-integrated model of regional FQHCs working together as members of a Clinically Integrated Network offer a promising opportunity to achieve cost savings and increase health in the community. By encouraging cooperation between primary care centers in a region it is possible to leverage population-based health analytics to better track patients, identify gaps in care, and assist in transitions of care. Pooled resources allow for improved centralized access to 24/7 nurse phone triage, improved urgent care availability, hospital-to-home transition teams, and health promotion communication campaigns. This can result in improved primary care that is directed by the FQHC that already has an established relationship with the patient. Care within the FQHCs also becomes more uniform, with standardized care management activities across health centers employing uniform treatment protocols for priority conditions that are identified as drivers of costly emergency room visits, hospital admissions, and readmissions. This type of collaboration and accountability

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[1] *National Health Expenditures 2015 Highlights*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf. Visited November 9, 2017.

[2] Tsugawa Y, Jha AK, Newhouse JP, *et al.* Variation in physician spending and association with patient outcomes. JAMA Int Med 2017; 177(5):675-682.

[3] Weiss A, Long SK, Ramos C, Coughlin T. Federally Qualified Health Centers' Importance in the Safety Net Continues as Affordable Care Act Implementation Moves Ahead (August 26, 2016). http://hrms.urban.org/briefs/federally-qualified-health-centers-importance-aca.html. Visited November 9, 2017.

across organizations can drive quality improvements through ongoing evaluations. Whitman-Walker is working with other FQHCs and the DC Primary Care Association to implement such a CIN.

The District of Columbia's Health Home II Program: My Health GPS. In addition to developing a local FQHC-based CIN through the DC Primary Care Association, WWH is participating in a "Health Homes" program through DC's Medicaid agency, the Department of Health Care Finance (DHCF). The program, "My Health GPS" (MHGPS), is designed to deliver care coordination to those Medicaid beneficiaries deemed eligible by the DHCF based on chronic disease burden and cost to the health system. The model funds (through a per-member, per-month payment) care coordination services to be delivered directly by the medical home in the primary care setting. Through funding provided by the Ryan White program, WWH has had more than 20 years of experience providing coordinated, team-based care to high-need patients (persons living with HIV/AIDS) and, therefore, our agency was able to adapt existing care teams to meet the goals of the MHGPS program. We have found that embedding care coordination in the primary care setting promotes the sharing of health information and development of collaborative relationships between medical providers and staff who provide supportive services. Importantly, these models also can provide a seamless experience for the patient, who can have many if not most of their health needs coordinated and provided by one agency.

The MHGPS program started on July 1, 2017. Whitman-Walker values the opportunity to participate in this initiative to better serve these high-need patients and to obtain funding for traditionally non-billable parts of the care team. We have identified several aspects of the current health home model that present opportunities to increase benefits to patients and further streamline the number of agencies and professionals involved in a patient's care. Discussed below, these suggested improvements would allow us more flexible care teams to respond to a range of patient physical and mental health and social needs.

(i) Flexibility in intervention design. The MHGPS model prescribes the maximum number of patients that can be served by a care coordination team, defines the roles and level of effort allowable for that team, limits the activities that can be conducted by the team, and delineates how often and by what mode staff must interact with a patient based on the patient's risk score. Our experience with the MHGPS program thus far has shown that these parameters are too narrow to address the highly variable needs of patients, and may also exceed the capacity of the health care workforce in the region. For example, only Registered Nurses are permitted to function as care managers. The model does not contemplate Licensed Social Workers in this role, although behavioral health and substance abuse needs are major drivers of hospital utilization in the District. We have had some difficulty recruiting sufficient RNs to serve in this role. In addition, the model relies heavily on community health worker (peer) roles, but DC does not have the infrastructure to create and support this workforce. Managing lay health workers requires a substantial investment of time and resources on the part of a health center and these

programs are often undergirded by government or academic resources.[4] A more flexible staffing model would allow us to utilize talent that we already have on staff or that we have direct experience in being able to successfully hire and train. For example, we have a number of highly trained and carefully supervised Public Benefits and Insurance Navigators and Retention Care Coordinators. While it is essential to have clearly-defined outcome measures, and to require participating health centers to define their interventions at the onset, there should be flexibility for staff on the ground to guide interventions based on their resources and known capabilities.

The MHGPS program also would be improved by modification of existing restrictions on the types and frequency of required/permitted interactions with patients. For example, patients who are rated as high-need based on their assigned risk scores are required to be served through face-to-face encounters. Effective services could be delivered to these patients in a variety of ways, including by phone, text, video conferencing, or through other mobile health platforms. Many of these patients may have trouble appearing in person or keeping scheduled home visits due to poor health or social barriers. Moreover, the program as currently configured requires that all enrolled patients must be assessed in person within 24 hours of a hospital discharge.   A more effective hospital transition program would be designed with more strata to reflect the very different needs patients may have upon leaving a hospital. Not all such patients need a full assessment; the considerable resources that in-person transition could more efficiently and effectively be directed to those specific patients who would benefit from such an intervention. Teams with specific skills could be dispatched to visit patients in the field based on specific factors such as: patients with known social barriers; those with cognitive or mental health challenges; those in need of wound care after surgery; newborns and their mothers. Additionally, an in-person visit to the health center may present unneeded challenges to patients who have been recently hospitalized. More flexible parameters for service delivery would permit the care team to deliver more effective as well as more efficient care.

(ii) Provision of seed money to establish care coordination teams. Care coordination requires resources to hire staff members and train them in their roles. An effective program can require some or all of the following: Registered Nurses; Licensed Social Workers; Care Coordinators; Care and Insurance Navigators; health educators; community or lay health workers; Health Information Technologists; and Health Data Analysts. Medical homes need investment dollars to be able to staff care coordination teams with sufficient lead time. A new scope of work – such as MHGPS care coordination – requires additional staff investment. Innovation models should contemplate the need for these resources in advance of launching programs, because health centers typically do not have the resources to self-fund these activities on a scalable level. Without advance investment, the effectiveness of the intervention is jeopardized; the health home may not be able to staff or carry out the full range of activities as specified by the model (and the evidence base). Under-staffing the activities may lead to the health home not earning a performance incentive, which could lead to further under-staffing or

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[4] California Health Workforce Alliance. *Taking Innovation to Scale: Community Health Workers, Promotores, and the Triple Aim. A Statewide Assessment of the Roles and Contributions of California's Community Health Workers.* Final Report December 2013, https://www.blueshieldcafoundation.org/sites/default/files/publications/downloadable/Taking_Innovation_to_Scale_CHWA_Report_Dec_2013.pdf. Visited November 19, 2017.

possible discontinuation of the program. This potential cycle of underfunding could be averted with up-front investments.

(iii) Designing models with goals in focus. The MHGPS program identifies system level outcomes such as reductions in hospital admissions and re-admissions; inappropriate emergency room use; and reductions in the total cost of care. However, the program's staffing and activities matrix does not directly tie to these goals. Participating health homes would be more likely to achieve the specified goals if the care coordination resources required by the program were more flexible. For example, instead of investing in fixed care coordination teams, a health home might opt to provide a service for patients that would aid them in avoiding the emergency room. Examples of such resources that are not contemplated in the MHGPS model include: triage nursing (either telephonic or face-to-face); on-demand transportation to health centers; support for health centers to expand hours and phone coverage; and support for health centers to make training and equipment investments in urgent and convenient care services. Allowable and required activities and staffing should be determined by "working backwards" from the performance targets, with sufficient flexibility to allow participating health centers to make adjustments as they learn what works.

CMS-Identified Model 7: Mental and Behavioral Health Integration

It is well understood the mental health and including substance abuse are significant drivers of emergency room use and hospitalizations.[5] It is also well understood that patients fare better when behavioral health needs are met by community providers and not by tertiary care providers such as hospitals.[6] WWH advocates building the capacity of primary care teams to meet the needs of patients with mental health and substance abuse needs. A necessary part of this work is reframing the concept of health to include mental and behavioral conditions and not just physical health. The degree to which primary care clinicians are trained and have the experience to treat non-serious mental illness is highly variable. Capacity-building programs in the primary care setting could include: universal screening for a range of behavioral needs; training primary care providers to prescribe behavioral pharmaceutical therapies; embedding mental health clinicians within primary care teams for rapid referrals; training mental health clinicians to deliver on-demand, brief, solutions-focused therapy in partnership with primary care providers; and increasing the capacity of non-licensed staff to administer mental health first aid.

WWH offers a continuum of behavioral health services, including:

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[5] Owens PL, Mutter R, Stocks C, Mental health and substance abuse-related emergency department visits among adults, 2007, Statistical Brief #92 (2010). Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project Statistical Briefs. https://www.ncbi.nlm.nih.gov/books/NBK52659.

[6] Krupski A, West I I, Scharf DM, *et al*. Integrating primary care into community mental health centers: impact on utilization and costs of health care. Psychiatric Services 2016*;* 67(11): 1233-1239. Available at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500424. *See also* Lardiere M, Jones E, Perez M. *NACHC 2010 Assessment of Behavioral Health Services Provided in Federally Qualified Health Centers*. National Association of Community Health Centers January 2011. Available at http://www.nachc.org/wp-content/uploads/2015/06/BHReport.pdf.

- Screening and assessment
- Mental health therapy – individual, group, peer support
- Psychiatry
- Substance use disorder treatment – outpatient acute stabilization, individual and group psychotherapy, relapse prevention, medication-assisted treatment (abstinence and harm reduction options)

To facilitate identification and treatment of behavioral health care needs, WWH has a Behavioral Health Specialist position on the primary health care team. The Behavioral Health Specialist assists patients and primary care providers to connect promptly with our behavioral health services; screens patients for behavioral health needs; provides crisis intervention and emergency room diversion; and provides short-term therapy to bridge transitions (into/out of care, major life events).

In addition to initiatives to integrate behavioral health with primary care, there is also a need for overall strengthening of the systems that support patients with serious and persistent mental illness. The Core Services Agencies that are charged with supporting these patients are hampered by unsteady funding streams; high staff turnover; and overwhelming caseloads. Under these conditions, these patients are too often treated in primary care or hospital settings, and neither setting is able to meet the need for long-term treatment of serious mental health needs. CMS should consider replicating models in jurisdictions where CSAs have been functional and successful partners to primary care providers.

The Importance of Addressing Social Determinants of Health in Models of Health Care Delivery

In addition to requesting comments on the specific delivery models listed, the RFI invites "any other comments or suggestions related to the future direction of the Innovation Center" (Part C, Question 7). We submit that it is critical to consider how health care delivery models can and should address key social determinants of health.

It is widely understood that social conditions have a significant impact on health outcomes. Such determinants including education, housing, employment, other income sources, and family and other social support networks. Socioeconomic status and race – which too often determines an individual's and family's education, housing, income and employment – directly correlate with health outcomes and life expectancy.[7] It is imperative that when creating health programs, such factors are not just considered, but are also embedded into programming. Tackling social determinants of health leads to improvements in health as well as lowering the cost of health care in general. A report in April 2017 from the Bipartisan Policy Center summaries that opportunities to control health care costs reside primarily in addressing patients' social and behavioral care needs. Such interventions have focused on home-based, patient-centered care; supportive housing; in-home meal delivery; and community-based assistive

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[7] Bipartisan Policy Center. *Improving Care for High-Need, High-Cost Medicare Patients.* April 25, 2017. https://bipartisanpolicy.org/library/improving-care-for-high-need-high-cost-medicare-patients.

services.[8] CMS should require health care entities to address a broader array of issues faced by patients, which may not have been considered "health concerns" in the past. CMS should require health centers to screen for such issues at medical visits; provide patients with resources to support access to health care; and require staff to be trained in cultural competency around contributing factors to health inequality such as race, ethnicity and national origin, and sexual and gender identity.

We also recommend that CMS provide support for health centers to co-locate social and legal services for patients with traditional medical and behavioral health services. Whitman-Walker has offered health-related and health-enabling social and legal services to our patients for nearly 40 years. As the first agency in Washington, DC to respond to the AIDS crisis in the early and mid-1980s, we offered an array of services when there was limited medical care available to HIV-positive patients. As we moved from an AIDS service organization to a full-service community health center, we continued our integrated approach to health care with a firm belief that addressing barriers to care and identifying social determinants of health positively impacts the patient's health and well-being and reduces health disparities related to race, ethnicity, gender, sexual orientation and income.

Our care team includes not only the typical medical provider and assistant, but also a lawyer, insurance navigator, referral specialist, behavioral health specialist, peer/community health worker, and others as needed. In this care team, the patient rather than the provider is at the center. In the registration process and by means of regular touches by different members of the care team, the patient is screened for any issues that may affect his or her ability to afford care, keep appointments, fully comply with treatment plans, and otherwise fully engage in care. If and when any such issues are identified, the patient is promptly connected to the specific care team member(s) best able to address those needs. Our philosophy is to employ our full range of health-supporting services – insurance navigators, attorneys, treatment adherence specialists, retention and community health workers – to engage patients and keep them anchored in care; provide them with access to the resources they need outside the health center to improve and protect their health; and empower them to take charge of their own health and wellness.

Social isolation is increasingly recognized as a contributor to poor health and inappropriate resource utilization.[9] Health programs that are successful provide social support for patients between medical encounters, enabling patients to make better use of the healthcare system and empowering them to better manage their conditions.[10] Whitman-Walker longstanding programs geared to addressing social isolation. One of our programs that most

[8] *Ibid.*

9 Petitte T, Mallow J, Barnes E, *et al.* A systematic review of loneliness and common chronic physical conditions in adults. Open Psychol J 2015; 8(Suppl 2):113–132. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4636039. *See also* Rico-Uribe LA, Caballero FF, Olaya B, *et al.* Loneliness, social networks, and health: a cross-sectional study in three countries. PLoS One 2016; 11(1):e0145264. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4711964.

[10] Roberts SR, Crigler J, Lafferty WE, *et al.* Addressing social determinants to improve healthcare quality and reduce cost. J Healthc Qual 2012; 34(2): 12-20.

effectively addressed social isolation in particularly high-need patients – our Day Treatment Program – was closed several years ago when DC Medicaid received guidance from CMS that it was not a Medicaid covered service. In addition to comprehensive day-treatment programs, "social prescribing," a practice which is gaining momentum in the United States in other countries, identifies health-beneficial activities and services available in the community, and supports patients to make use of them. These may include: volunteering or community projects; arts projects, and support groups.[11] WWH recommends that CMS support studies or demonstration projects to establish the evidence base for the effectiveness of these interventions. In the long range, such interventions are likely to be more cost-effective than the provision of clinical care alone, and will deliver quality of life benefits to the patients served.

CONCLUSION

Whitman-Walker Health appreciates the opportunity to provide information and comments as the agency works on its strategic vision going forward. We offer to serve as a resource or provide additional information regarding this submission as necessary. If we can provide additional information, please contact Erin Loubier, eloubier@whitman-walker.org, (202) 939-7662.

Respectfully,

Meghan Davies, MPH, CPH, CHES, Chief of Operations and Program Integration
Sarah Henn, MD, MPH, Senior Director of Health Care Operations
Erin M. Loubier, JD, Senior Director of Health and Legal Integration and Payment Innovation
Rachel McLaughlin, MA, Senior Director of Population Health and Quality
Daniel Bruner, JD, MPP, Senior Director of Policy

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[11] Mann F, Bone JK, Lloyd-Evans B, *et al.* A life less lonely: the state of the art in interventions to reduce loneliness in people with mental health problems. Soc Psychiatry Psychiatr Epidemiol 2017; 52(6): 627-638. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5487590.