Partnership
to Align Social Care

A National Learning
& Action Network

September 11, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via http://www.regulations.gov.

RE: CMS-1784-P: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies

Dear Administrator Brooks-LaSure:

On behalf of the co-chairs of the Partnership to Align Social Care (Partnership), which serves as a national learning and action network with the purpose of advancing the alignment between healthcare and social care service delivery systems, and the below signed organizations representing numerous health and social care sector stakeholders, we are writing in response to the *Proposed Rule [CMS-1784-P] Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Polices; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Polices, and Basic Health Programs.*

The Partnership has brought together leaders from across the healthcare and social care sectors, including health plans, health systems, providers, community-based organizations, national associations, and government representatives that share the common goal of supporting efficient and sustainable ecosystems needed to provide individuals with holistic, equitable, community-focused, and person-centered care. Achieving this shared vision includes pursuing opportunities to enhance and sustain contracted partnerships between healthcare entities and social care providers, particularly community-based organizations organized into networks led by community care hubs.

Aligning the proposed rule with the administration's promises to improve supports for individuals and families receiving health-related social needs (HRSNs)

We commend the Centers for Medicare and Medicaid Services (CMS) for including several historic proposals in the draft rule that align with and promote opportunities to achieve core policy principles outlined in various administration initiatives to improve opportunities for individuals and families to receive social supports that address HRSNs.

These important frameworks include, but are not limited to:

- *Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*
- *HHS Strategic Approach to Addressing Social Determinants of Health to Advance Health Equity*
- *MS Behavioral Health Strategy*

We appreciate that CMS has incorporated proposals within the CY 2024 Physician Fee Schedule to leverage existing agency authorities to recognize and address systemic barriers to healthcare services and benefits for people of color and other historically underserved groups, as well as patients, families, and caregivers. Overall, HHS and CMS serve a critical role in ensuring that the federal government achieves the ambitious, but essential, goals included in these national commitments. The annually updated Physician Fee Schedule provides an ongoing opportunity to identify, implement, and improve policies to improve alignment between health care and social care ecosystems.

Specifically, the undersigned organizations and the co-chairs of the Partnership to Align Social Care offer the following comments in response to core components in the CY 2024 Physician Fee Schedule including Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services); and Expansion of Health Behavior Assessment and Intervention (HBAI) services to clinical social workers (CSWs), marriage and family counselors (MFCs), and mental health counselors (MHCs). These comments were prepared in large part by Partnership Co-Chair Timothy P. McNeill, RN, MPH, CEO of Freedmen's Health Consulting, and represent the broad input of Partnership stakeholders, including those that were unable to sign on directly to this letter.

1. Community Health Integration (CHI) Services:

We applaud CMS for taking the expansive step to recognize the distinct impact that HRSNs contribute to negative health outcomes and increased total cost of care for high-need beneficiaries. The proposed creation of new Healthcare Common Procedure Coding System (HCPCS) codes for community health integration, social determinants of health risk assessment, and principal illness navigation services are the most forward-thinking approach proposed by CMS for creating a pathway for providers to sustain the essential contribution of auxiliary personnel such as community health workers, peer support specialists, and community-based organizations/community care hubs in addressing HRSNs when implementing a whole person model of care. In moving toward implementation, we look forward to working with CMS in collaboration with community-based, non-traditional, worker groups that use a lived experience framework to ensure auxiliary personnel are working within their scope of practice.

After a detailed analysis of the proposed rules, we have developed the following comments for your review and consideration:

a) Initiating Visit: The proposed rule limits the initiating visit for CHI to an eligible Medicare provider evaluation and management (E/M) visit. We support the requirement for an initiating visit, but we also believe that many providers will conduct HRSN screening during an annual wellness visit. ***As a result, we recommend that CMS include the Annual Wellness Visit (AWV) in the list of qualifying medical encounters for CHI services.*** Physicians and non-physician practitioners (NPPs) should be allowed to initiate CHI services during the AWV because a

comprehensive wellness plan must include the impact of HRSNs on whole person care. When a provider creates a wellness plan, during an AWV visit, it is important to determine if there are HRSNs that will negatively impact the implementation of the wellness plan. For example, it is imperative for a provider to determine if there are transportation challenges incurred by the beneficiary or housing insecurity when developing the wellness plan because these HRSNs will directly impact the ability of the beneficiary to complete the required elements in the wellness plan. In addition, the provider should note any HRSNs in the wellness plan that will directly impact the implementation of the plan. ***The recognition of the integral role of HRSNs in implementing a wellness plan underscores the need to include the AWV as an eligible initiating visit for CHI services.***

Secondly, a transitional care management visit is a type of E/M visit that should be explicitly included in the list of eligible initiating encounters for CHI services. The rationale for highlighting the transitional care management visit as an initiating visit for CHI services is the fact that HRSNs, such a housing insecurity, directly impact hospital length of stay. Providers that provide transitional care management services must be cognizant of HRSNs in developing the transition plan, after an acute care hospitalization.

b) Same Practitioner Limitation: The proposed rules list that the same practitioner that conducts the initiating visit would furnish and bill for both the CHI initiating visit and the CHI services. In many primary care settings, including federally qualified health centers (FQHCs) and rural health centers (RHCs), physicians and NPPs (Physician Assistants and Nurse Practitioners) operate as care teams. This is particularly true in health professional shortage areas (HPSAs) where the beneficiary may be seen by more than one provider in a group practice, but each provider adheres to a shared care plan within the group practice. When multiple providers in a group practice operate as a clinical care team, each of the providers in the group practice would be working in support of the same clinical care plan. Alternatively, one or more of the providers in the same group practice may conduct the initiating visit and a different provider in the group may oversee the subsequent CHI services. We strongly believe that limiting CHI initiating visit and CHI services to the same individual provider, without recognition of group practices that employ NPPs that may initiate the qualifying visit, would impair the ability of nurse practitioners and physician assistants to contribute to CHI service delivery that supports the individual care plan with definitive HRSN goals.

The CY 2015 Physician Fee Schedule Final Rule supported the inclusion of other providers in the group practice supporting the delivery of general supervision of other providers in a group practice setting. ***We urge CMS to honor the policy of recognizing more than one provider in the same group practice conducting the initiating visit and the subsequent "incident to" general supervision delivery of CHI services and PIN services.***

> *"Therefore, we proposed to revise our regulation at § 410.26, which sets out the applicable requirements for ''incident to'' services, to permit TCM and CCM services provided by clinical staff incident to the services of a practitioner to be furnished under the general supervision of a physician or other practitioner. As with other ''incident to" services, the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the ''incident to" service is based. We note that all other ''incident to'' requirements continue to apply and that the usual documentation of services*

provided must be included in the medical record". Federal Register. Vol. 79, No. 219. Thursday, November 13, 2014.

c) General Supervision of Auxiliary Personnel: ***We enthusiastically support the implementation of General Supervision requirements for the provision of CHI services that are provided by auxiliary personnel.*** We also fully support the specific reference to Community Health Workers being part of the eligible paraprofessionals that can implement CHI, operating under general supervision of the Medicare provider or NPP. ***However, we urge CMS to also identify social workers, including social workers trained at the Bachelor of Social Work (BSWs) level, as eligible auxiliary workforce under CHI and PIN. As auxiliary personnel supporting the delivery of CHI and PIN, BSWs would work under the general supervision of the eligible Medicare Provider. This inclusion is especially important as auxiliary personnel are employed by community care hubs and/or individual CBOs that may be contracting with a Medicare billing provider, and BSWs make up a significant part of this workforce.***

d) Role of Community-Based Organizations: ***We enthusiastically support the definitive reference and inclusion of community-based organizations and community care hubs, contracting as third-party organizations with eligible Medicare providers, to deliver CHI services.*** Safety net providers and physician practices that serve large volumes of high-need populations are often undercapitalized and may lack the infrastructure to hire additional personnel to deliver and supervise CHI services. These practices could leverage the option of contracting with a community-based organization, such as a local area agency on aging, aging and disability resource center, center for independent living, or other community-based organization to provide staff augmentation to deliver CHI services. This will allow eligible Medicare providers to leverage local community assets that have intricate knowledge of the social service system and are often the experts in social care navigation. ***We strongly recommend that CMS specifically outline the option of contracting with community-based organizations as an option for providers to consider when establishing an implementation plan for CHI services.***

e) Codes and Descriptors: **We applaud CMS for creating a stand-alone HCPCS code (GXXX1) for *Community Health Integration Services performed by certified or trained auxiliary personnel, including a community health worker, peer support specialists, or social worker, under the direction of a physician or other practitioner; 60 minutes per calendar month*.** We note that CHI services will generally occur over multiple months. Persons with complex social needs often have two or more HRSNs that are interdependent. The provider will need considerable time to fully address each of the identified HSRNs that are negatively impacting health outcomes. This time will be required to address the needs of beneficiaries that have more than one HRSN. The data from the Accountable Health Community (AHC) model demonstrated that the majority
of beneficiaries screened had 2 – 5+ HRSNs. In order to address 2 – 5+ HRSNs, it is conceivable that the CHI Services would occur over multiple months. Each month the time spent delivering CHI services would be aggregated to determine the total time spent per calendar month.

During the first month of delivering CHI services, it is essential to include considerable time identifying full range of HRSNs impacting the beneficiary; locating area resources that match the

identified HRSNs; developing a person-centered plan to address each HRSN; reviewing the eligibility criteria for each social care program included in the person-centered plan; and assisting the beneficiary with applying for all potential social care resources. The subsequent months, during CHI service delivery, there may not be the same intensity of time spent delivering CHI services, as compared to the initial month. In subsequent months of delivering CHI services, the auxiliary personnel may spend less time checking the status of social care applications submitted on behalf of the beneficiary. As a result, there may be less time spent in the subsequent months, where the 60-minute threshold may not be met. ***As a result, we strongly recommend that CHI services be formatted in the same manner that time is allotted for non-complex chronic care management services – 20-minute increments for the first hour and then an add-on code for each 30-minute increment beyond the first 60 minutes. We propose that the GXXX1 code cover CHI services in 20-minute increments, for up to the first 60 minutes in a calendar month, for a maximum total of three (3) units. After three (3) units, or 60 minutes, the provider would then bill for additional services in 30-minute increments.***

f) Health education and facilitating behavioral change: ***We applaud CMS for listing CHI service categories that includes the provision of health education and services to facilitate behavior change.*** The science regarding health education models that support sustainable behavior change includes the provision of evidence-based programs that are delivered as individual and group interventions. The Centers for Disease Control and Prevention (CDC) and the Administration for Community Living (ACL) have recognized a range of evidence-based programs that have undergone randomized controlled trials to support health education and behavior change for chronic disease self-management, fall prevention and other categories of disease self-management. Most of these health education and disease promotion evidence-based programs include group interventions. As a result, the provision of CHI services to include health education and behavior change interventions should include a reimbursement HCPCS code for group services. The current proposed rule does not include a HCPCS code for CHI services provided to a group of beneficiaries. The limitation on providing group CHI services would cause providers to limit access to evidence-based behavior change programs that require group-based interventions. ***As a result, we strongly recommend that CMS create a HCPCS code for group CHI services to allow providers to implement evidence-based behavior change interventions identified by CDC and ACL as effective evidence-based interventions in group settings.***

g) Consent for CHI Services: CHI Services are provided as face-to-face and non-face-to-face interventions. **A substantial number of CHI services are performed as a non-face-to-face intervention working *on behalf of* the beneficiary.** For example, when auxiliary personnel are working to address housing insecurity, a considerable amount of time may be spent calling potential housing providers to determine if there are current vacancies that meet the financial and accessibility requirements of the beneficiary. Once one or more potential housing options are identified, the auxiliary personnel would have to secure the application, determine the application submission requirements, and then review the findings with the beneficiary.

Because a considerable amount of CHI services time would be spent delivering non-face-to-face interventions, the proposed consent process for CHI services should include a verbal consent option that is documented in the clinical record. Auxiliary personnel operating under

general supervision should be allowed to secure verbal consent if the auxiliary personnel are trained, have documented the information reviewed with the beneficiary, and capture it in the electronic medical record. It is imperative that there are specific details reviewed with the beneficiary during the verbal consent process related to cost sharing requirements given the fact that many CHI services will be delivered as non-face-to-face encounters. ***In addition, verbal consent should be required only once per calendar year that CHI services are required.***

h) CHI Services while the patient is under a home health plan of care under Medicare Part B: CHI services would be delivered based on an overall plan of care. Many of the CHI services would address very complex needs, such as housing insecurity. Interventions to address housing insecurity often require multiple interactions over time. During the time that CHI services are being provided, the beneficiary may require home health services such physical therapy. However, CMS is proposing that the CHI services would have to be discontinued during the time that home health services are being provided such. The rationale is that the home health benefit has a social service component. However, the social service component is very limited and home health services are generally only sixty (60) days in duration. ***The proposal to prohibit concurrent provision of CHI services and home health plan of care could cause a disruption in the continuity of care for addressing HRSNs***. In addition, this would place the beneficiary in a position to have to choose between receiving services addressing multiple complex needs–for example housing assistance/services versus ongoing physical therapy–because it is extremely unlikely that the social service component of a limited sixty (60) day home health benefit would provide continuous social care interventions that were initiated by auxiliary personnel at the Medicare Provider practice. In addition, home health plans of care are often initiated after an inpatient hospitalization. It is well established that social conditions, such as housing insecurity, are complicating conditions of acute hospitalization, which can be a triggering event for home health aide benefits. ***As such, we strongly urge CMS to allow for concurrent billing of CHI services and skilled home health plan of care because it is well established that the limited social work component of a home health plan of care is not adequate to address complex HRSNs and does not include the same intensity of support that is outlined in the CHI services benefit.***

Furthermore, we urge CMS to take the appropriate precautions to ensure that Home Health Agencies (HHAs) are aware that HRSNs are an inappropriate and inadequate substitution or replacement for Medicare-covered home health aide services. Utilization of home health aide services has precipitously declined in the past two decades despite no change to benefit policy. Therefore, we strongly urge CMS to ensure
that the provision of HRSN services does not further erode already dwindling access to home health aide services for qualifying beneficiaries.

i) Proposed CHI Services Valuation: For HCPCS code GXXX1, CMS is proposing a work RVU of 1.00 based on a crosswalk to CPT code 99490. We strongly agree that the CHI services has a RVU that directly crosswalks to the Chronic Care Management RVU. However, we note that chronic care management services are billed under CPT code 99490 for the first twenty (20) minutes and then CPT code 99439 is billed in 20-minute increments (non-complex chronic care management), up to the first 60 minutes, during the calendar month, using the following coding:

i. 99490: First 20-minutes of non-complex chronic care management (National Rate = $60.15)
ii. 99439: Each subsequent 20-minutes of non-complex chronic care management (National Rate = $45.46.
iii. For the initial 60-minutes per calendar month of chronic care management the national rate would be the following 99490 + 99439 + 99349 = $151.07 per beneficiary/60 minutes of non-complex chronic care management per calendar month

We agree that the RVU for HCPCS code GXXX1 should have a work RVU of 1.00 based on a crosswalk to CPT code 99490 but the RVU crosswalk should not be limited to the first 20 minutes of CHI services. Every subsequent twenty (20) minutes of CHI up to sixty (60) minutes should have a separate HCPCS code that has an equivalent RVU crosswalk to 99490 and 99439, up to sixty (60) minutes per calendar month.

For HCPCS code GXXX2, CMS is proposing the work RVU associated with CPT code 99439. We agree with the RVU for GXXX2 as long as there is recognition that the first hour can be billed in 20-minute increments up to a total of 60 minutes.

j) FQHC/RHC Reimbursement for CHI/PIN Services: CMS is proposing to allow FQHCs/RHCs to be reimbursed for community health integration (CHI) and principal illness navigation (PIN) services. However, CMS is proposing to include both CHI services and PIN services in the same established code for care management services – G0511. In fact, CMS is proposing to include all chronic care management services, community health integration services, principal illness navigation services, and remote patient monitoring in one HCPCS code (G0511). CMS proposes to include CHI services using HCPCS Code G0511 for CHI and PIN Services with no allowance for add-on codes based on time. The rationale given is that FQHCs and RHCs do not pay their medical providers based on time but based on encounters. However, it is notable that CHI and PIN Services will be delivered by auxiliary personnel such as community health workers, peer support specialists, and social workers. These workers are generally paid based on time and not based on encounters as a medical provider would be compensated. Given that the primary labor category for delivering CHI services and PIN Services, in a FQHC/RHC, would be auxiliary personnel to include CHWs or social workers, there should be a provision for FQHCs/RHCs to receive additional compensation based on actual time spent. The FQHC/RHC will incur additional expenses when CHI/PIN services are provided
for an extended period because the primary labor category for CHI/PIN services would be community health workers and other auxiliary personnel that are paid on an hourly basis. ***We recommend that CMS create a standalone HCPCS code for CHI and PIN services that will account for the time-based compensation model, which is the standard compensation model deployed for the primary labor force delivering CHI/PIN services.***

Secondly, the inclusion of CHI and PIN services in a bundled code for numerous care management services has the potential for FQHCs/RHCs incurring denied claims for duplicate encounters. It is notable that in the CY 2023 Final Rule, CMS listed the following provision to allow for FQHCs/RHCs to submit more than one G0511 claim per month, but the guidance does not address the potential of more than one G0511 claim occurring on the same day for the same beneficiary:

"*Response:* We note that we did not specifically make any proposals in the CY 2023 PFS

> proposed rule to simultaneously bill CCM or BHI service in the same calendar month. In the CY 2021 PFS final rule with comment (86 FR 84699), we finalized a policy that general care management services furnished in RHCs and FQHCs can only be billed once per month per beneficiary when at least 20 minutes of CCM services, at least 30 minutes of PCM services, or at least 20 minutes of general BHI services have been furnished and all requirements have been met. Therefore, if the requirements for each of these care management services are met, then HCPCS code G0511 can be billed more than once in a calendar month, either alone or with other payable services and the same would apply for CPM and GBHI" *Federal Register, Vol. 87, No. 222/Friday, November 18, 2022. Rules and Regulations. Page 69736*.

While it is assumed that the G0511 code will allow for more than one claim to be submitted per calendar month for the delivery of CHI and PIN services, ***it is not clear if more than one G0511 encounter can be billed on the same day for the same beneficiary***. Given the broad range of care management services that CMS is proposing to bundle into one HCPCS Code (G0511), ***it is conceivable that a consumer would receive more than one care management service on the same day***. When a FQHC/RHC delivers more than one care management service on the same day – and all requirements are met for each care management service, the G0511 claim does not allow for multiple units of service to be billed for the same beneficiary, on the same day, under the same G0511 code. Therefore, a FQHC/RHC could not be compensated when more than one care management service is provided to the same beneficiary on the same day. In addition, the submission of multiple G0511 claims on subsequent, successive days has the potential of claims denial as the system would note that these are potentially duplicate claims.

CMS has set a precedent for establishing a separate HCPCS code for a unique care management service. To clearly delineate chronic care management services from collaborative care management behavioral health integration services, CMS created a separate HCPCS code for Collaborative Care Management – G0512. ***We strongly recommend that CMS consider a stand-alone HCPCS code for community health integration and principal illness navigation services to prevent the potential of claim denials for duplicate billing when FQHCs/RHCs provide more than one care management service to the same beneficiary on the same day or in successive days, after an initiating visit.***

The need to separate the HCPCS code for FQHC/RHC claims is particularly important because the high-need populations largely served by FQHCs/RHCs makes this population likely to have a higher percentage of beneficiaries that are negatively impacted by HRSNs. 2022 data from the National Association of Community Health Centers (NACHC) reports that community health centers have served over 30 million patients in 2021. Of these 30 million patients, 90% are low-income and 65% are members of a racial and/or ethnic minority (Available Online: https://www.nachc.org/resource/americas-health-centers-2022-snapshot/)

Socioeconomic status and/or being a racial and/or ethnic minority increases the risk of being negatively impacted by health-related social needs. As a result, community health centers are more likely to encounter Medicare beneficiaries that require CHI services. The current proposed rules allow non-FQHCs/RHCs concurrent billing for CHI services and chronic care management. ***We strongly urge CMS to consider creating a stand-alone CHI/PIN services***

HCPCS code for FQHCs/RHCs. We strongly advise against combining all care management services into one G0511 code that is limited to once per beneficiary per month.

2. <u>Social Determinants of Health Risk Assessment</u>

CMS is proposing a new stand-alone G code GXXX5, Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment. We generally applaud the creation of a HCPCS code to complete an evidence-based SDOH risk assessment. However, the GXXX5 code is limited to a necessary E/M visit. Screening to identify health-related social needs is an important component of a comprehensive and accurate wellness plan developed during an annual wellness visit. A provider must determine if HRSNs will impair the ability of the beneficiary to complete the required preventive health screening in the wellness plan. ***We urge CMS to clarify that providers are allowed to bill for the GXXX5 code during an annual wellness visit. In addition, screening and addressing health-related social needs should occur during a transitional care management visit as an eligible E/M visit for the provision of GXXX5.***

3. <u>Principal Illness Navigation</u>

Navigation services are an essential tool in addressing the needs of persons with complex conditions. ***We applaud CMS for recognizing the need to capture the labor required to fully address the complex needs of persons with serious, high-risk disease that is expected to last at least 3 months and for recognizing the need to capture the labor required to implement navigation services***. Based on our experience providing navigation services for persons with advanced dementia, we estimate that the average duration of PIN services is 3 – 6 months.

a) <u>Initiating Visit</u>: The proposed rule limits the initiating visit for PIN services to an E/M visit. ***We also believe that many providers will initiate navigation services to address a catastrophic diagnosis during an annual wellness visit***. It is notable that many providers conduct annual screening for cognitive decline as part of an annual wellness visit encounter. Indications for cognitive decline that are discovered during an annual wellness visit could lead to the need to provide navigation services if a diagnosis of dementia is discovered during an AWV. ***As a result, the AWV should be an allowable initiating visit for PIN services***.

In 2015, CY 2016 Physician Fee Schedule final rule, CMS made the following rule regarding the provision of Advanced Care Planning during an Annual Wellness Visit: "We are instructing that when ACP is furnished as an optional element of AWV as part of the same visit with the same date of service, CPT codes 99497 and 99498 should be reported and will be payable in full in addition to payment that is made for the AWV under HCPCS code G0438 or G0439, when the parameters for billing those CPT codes are separately met, including requirements for the duration of the ACP services" *Federal Register. Vol. 80, No. 220, Monday, November 16, 2015. Page 70958.*

The Advanced Care Planning encounter is often completed when there is a serious illness that requires the beneficiary to participate in end-of-life planning. If Advanced Care Planning is conducted during the AWN and fully compensated per this CY 2016 PFS instruction, the AWV should be included as an initiating visit for PIN services.

Secondly, a transitional care management visit is a type of E/M visit that should be explicitly included in the eligible initiating visit services for PIN services. Complex medical conditions are often identified during an acute hospitalization. The post-discharge medical visit would be a transitional care management encounter. ***We urge CMS to include an explicit reference to transitional care management visits as a qualifying encounter for PIN services.***

b) Same Practitioner Limitation: The proposed rules list that the same practitioner that conducts the initiating visit would furnish and bill for both the PIN initiating visit and the PIN services. In many primary care settings and FQHCs/RHCs physicians and NPPs operate as care teams. This is particularly true in areas where there is a physician shortage area. As a result, the beneficiary may be seen by more than one provider in a group practice. However, each of the providers in the group practice operates as part of a clinical team and would be working in support of the same clinical care plan. As a result, the individual provider that conducts the PIN initiating visit may not always be the same individual provider that conducts the PIN services. Alternatively, one or more of the providers in the same group practice may conduct the initiating visit and the subsequent PIN services. Limiting the PIN initiating visit and PIN services to the same individual provider without recognition of group practices that employ NPPs would impair the ability of nurse practitioners and physician assistants in the group practice from supporting the individual care plan with definitive HRSN goals. ***Therefore, we urge CMS to clarify that the PIN initiating visit and PIN services apply to the group practice level and not be limited to the individual provider level.***

As referenced earlier, the inclusion of other providers in the group practice supporting the delivery of general supervision of other providers in a group practice setting was outlined in the CY 2015 Physician Fee Schedule Final Rule.

c) General Supervision of Auxiliary Personnel: ***We enthusiastically support the implementation of General Supervision requirements for the provision of PIN services that are provided by auxiliary personnel***. We also fully support the specific reference to community health workers and peer support specialists being part of the eligible paraprofessionals that can implement PIN, operating under General Supervision of the Medicare Provider or NPP. ***However, we recommend clarifying that social workers, including social workers trained at the Bachelor of Social Work (BSW) level, are eligible paraprofessional auxiliary providers that can implement PIN as well.***

d) Role of Community-Based Organizations: ***We enthusiastically support the definitive reference and inclusion of community-based organizations contracting as third-party organizations with eligible Medicare Providers to deliver CHI services***. Physician practices that serve vulnerable populations are often undercapitalized and may lack the infrastructure to hire additional personnel to deliver and supervise PIN services. These practices could employ the option of contracting with a community care hub or an individual community-based organization, such as a local area agency on aging, aging and disability resource center, center for independent living, or other community-based organization to provide staff augmentation to deliver CHI services. ***This will allow eligible Medicare providers to leverage local community assets that have intricate knowledge of the social service system and are often the experts in social care navigation. We feel strongly that it is important for CMS to specifically state the option of contracting with a community care hub or individual community-based organization as one***

option that can be considered when implementing PIN services.

e) PIN Services Concurrent Billing: ***We enthusiastically support the proposal to allow for concurrent billing for principal illness navigation services and other care management services, as long as long as time spent on a given activity is only counted toward one code***.

f) Proposed PIN Services Valuation: In the proposed rule, CMS states the following: *"For HCPCS code GXXX3, we are proposing a work RVU of 1.00 based on a crosswalk to CPT code 99490 (Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored…"*

We note that chronic care management is billed in the following manner CPT code 99490 for the first 20 minutes and then CPT code 99439 is billed in 20-minute increments (non-complex chronic care management), up to the first 60 minutes, during the calendar month, using the following coding:

i. 99490: First 20-minutes of non-complex chronic care management (National Rate = $60.15)
ii. 99439: Each subsequent 20-minutes of non-complex chronic care management (National Rate = $45.46.
iii. For the initial 60-minutes per calendar month of chronic care management the national rate would be the following 99490 + 99439 + 99349 = $151.07 per beneficiary/60 minutes of non-complex chronic care management per calendar month

We agree that the RVU for HCPCS code GXXX3 should have a work RVU of 1.00 based on a crosswalk to CPT code 99490 but the RVU crosswalk should not be limited to the first 20 minutes of CHI services. Every subsequent twenty minutes of PIN, up to 60 minutes, should have a separate HCPCS code that has an equivalent RVU crosswalk to 99490 and 99439, up to 60 minutes per calendar month.

g) Consent for PIN Services: PIN Services are provided as face-to-face and non-face-to-face interventions. **A substantial number of PIN services are performed as non-face-to-face interventions working *on behal*f of the beneficiary.** For example, when auxiliary personnel are providing navigation services for a beneficiary with advanced dementia, a considerable amount of time may be spent as non-face-to-face services spent on behalf of the beneficiary with advanced dementia. Some of the PIN services time spent working on behalf of the beneficiary could include calling assisted living facilities, memory care units, home health agencies that specialize in dementia care, and other service providers to determine if there are current vacancies and services available based on identified needs of the beneficiary.

Because a considerable amount of PIN services time would be spent delivering non-face-to-face interventions, the proposed consent process for PIN services should include a verbal consent option that is documented in the clinical record. Auxiliary personnel operating under general supervision should be allowed to secure verbal consent if the auxiliary personnel are

trained, have documented the information reviewed with the beneficiary, and capture it in the electronic medical record. It is imperative that there are specific details reviewed with the beneficiary during the verbal consent process related to cost sharing requirements given the fact that many PIN services will be delivered as non-face-to-face encounters. ***In addition, verbal consent should be required only once per calendar year that PIN services are required.***

4. <u>Expansion of Health Behavior Assessment and Intervention (HBAI) services</u>

HBAI is an important Medicare Part B benefit established to address the behavioral, cognitive, emotional, or psychosocial factors that affect the treatment or management of one or more physical health conditions. HBAI services can be offered to address a variety of issues that affect an individual's physical health status, such as barriers to adherence to the clinical treatment regimen, symptom management, risk-taking behaviors, cultural factors, lifestyle behaviors, limitations in implementing health-management related problem-solving techniques, or coping with a chronic illness. HBAI is not a benefit that is established to treat or manage a mental illness that impairs a beneficiary's ability to manage their chronic disease. Treatment and management of mental health conditions must be performed using the appropriate behavioral health treatment codes. The interventions included in the HBAI benefit are within the scope of practice of licensed clinical social workers (LCSWs). The current regulatory prohibition of LCSWs, delivering HBAI services, as an independent Medicare provider, has significantly impaired the adoption and utilization of the HBAI benefit by eligible beneficiaries. ***We enthusiastically support the expansion of the HBAI eligible provider list to include LCSWs.*** LCSWs operate in multiple clinical settings as both independent Medicare providers of behavioral health services, such as psychotherapy, and in group practices. HBAI services are within the scope of practice of LCSWs. Therefore, recognizing LCSWs as independent providers of HBAI services will allow for more Medicare beneficiaries to receive this critically important service.

Furthermore, we appreciate that the proposed rule aligns with the CMS Behavioral Health Strategy and effort to support a person's emotional and mental well-being through their behavioral health care. We agree with CMS that this rule contains some of the most important changes to improve behavioral health in Medicare in the program's history including allowing clinical social workers, marriage and family therapists, and mental health counselors, including addiction counselors, to enroll as individual Medicare providers and bill for their services. Given that an estimated one in four Medicare beneficiaries live with a mental or behavioral health condition, it is critical for physical health care to incorporate care that addresses the complexity of factors influencing people's medical treatment. Expanding access to HBAI services does just that. Community-Based Organizations that employ Clinical Social Workers could enroll as a Medicare provider and independently deliver HBAI services. The expansion of HBAI services in community settings and delivered by community-based Clinical Social Workers will have the potential to significantly impact the lives high-need populations that are disproportionately affected by multiple chronic conditions.

Conclusion

We appreciate the Centers for Medicare & Medicaid Services innovative approach to recognizing the need to screen and address health related social needs among the traditional Medicare beneficiary population. Establishing new HCPCS codes for screening and addressing health related social needs

and navigation services is an historic and monumental advancement toward effectively and sustainably aligning health and social care. We strongly advocate for the Community Health Integration services, Principal Illness Navigation services, and Social Determinants of Health Risk Assessment to become permanent Medicare Part B benefits. If the proposed rules become final it will be critically important to fund, create, and implement technical assistance resources to assist eligible providers with developing sustainable implementation models and uplifting leading practices for replication across the country.

On behalf of the co-chairs of the Partnership to Align Social Care and the below signed organizations representing multiple health and social care sector stakeholders across the country, we appreciate the opportunity to comment on the proposed rules for the CY 2024 Physician Fee Schedule. Should you have any questions, please reach out to Partnership Director, Autumn Campbell (acampbell@partnership2asc.org) or 202-805-6202.

Sincerely,
Timothy McNeill, RN, MPH and June Simmons, MSW
Co-Chairs, Partnership to Align Social Care

SIGNING ORGANIZATIONS
AgeSpan, Inc.
American Association on Health and Disability
Beacon Community Connections
Center for Health and Social Care Integration at RUSH
Comagine Health
Community Access Network
Community Care Cooperative (C3)
Detroit Area Agency on Aging
Direction Home Akron Canton Area Agency on Aging & Disabilities Food
Is Medicine Coalition
Freedmen's Medicine
Inclusive Alliance IPA
Independent Living Systems, LLC
Iowa Community HUB
Lakeshore Foundation
Mac Inc -Maryland Living Well Center of Excellence
National Council on Aging
Ohio Association of Area Agencies on Aging
Oregon Wellness Network
Partners in Care Foundation
Perham Health
Piedmont Triad Regional Council
Sustainable Health Systems Corporation
The Caregiving Years Training Academy
The National Association of Nutrition and Aging Services Programs (NANASP) Tim
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