Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1784-P
Mail Stop C4-26-05
Baltimore, MD 21244

September 11, 2023

RE: Response to the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule (PFS) proposed rule for calendar year 2024.

Dear Administrator Brooks-LaSure:

The ***Pennsylvania Community Health Worker*** **(CHW)** ***Collaborative*** (hereby referred to as "The Collaborative") is pleased to provide comments on the CMS Physician Fee Schedule proposed rule for calendar year 2024. The Collaborative is a statewide coalition that facilitates active collaboration, education, advocacy, and support for Pennsylvania (PA) CHWs. With over 300 members consisting of CHWs, payers, community-based organizations (CBOs), health systems, Federally Qualified Health Centers (FQHCs), community health centers, health care providers, licensed birth centers, and funders, the Collaborative prioritizes CHW leadership and decision-making to advance its mission. Since 2020, the Collaborative's CHW sustainability committee, consisting of over 51% CHW membership, has focused primarily on advocacy to support the authorization of payment for CHW services through the PA Medical Assistance program. This committee has also led the effort to develop the enclosed comments.

We applaud CMS for taking this groundbreaking and unprecedented step in building the infrastructure needed to sustain and advance the CHW workforce. We appreciate recognition of CHWs as individuals who improve health outcomes, advance health equity, reduce barriers related to unmet health-related social needs (HRSNs), and coordinate care that provides vulnerable beneficiaries with whole-person support. The proposed development of new codes for community health integration (CHI), social determinants of health risk assessment (SDOH), and principal illness navigation (PIN) services will be essential to the financial sustainability of the workforce, particularly for CHW employers that are largely grant funded. Through our statewide advocacy efforts, we found that 58% of CHW positions in PA are funded by short-term grants, and only 10% are funded by Managed Care Organizations (MCOs), making long-term planning and continuity of programming tenuous (2023 PA CHW Employer Survey, n=100).

After a thorough review of the proposed rule, we have developed the following comments related to CHI services for your review and consideration:

a. <u>Initiating Visit:</u> The proposed rule allows CHI initiating visits to occur only at Evaluation/Management (E/M) visits. While we support the requirement for an initiating visit, we also know that SDOH screenings are more commonly conducted in other clinical and non-clinical settings, including but not limited to, annual wellness visits (AWVs), emergency department

(ED) visits, home settings, community settings, and at community-based organizations (CBOs) that do not provide health care services. We recommend allowing for a broader range of qualifying visits/services and provider types to initiate CHI services, such as AWV, ED, home visits, and community-based care organization (CBO) visits. Vulnerable Medicare beneficiaries most in need of health care services are often not engaged with a Primary Care Provider (PCP) or other health care provider, making CHW services and linkages to care even more critical from the beginning. For example, beneficiaries looking to address personal barriers related to SDOH may be more likely to visit a CBO offering housing assistance, food assistance, or transportation assistance for immediate unmet HRSNs than a health care provider. In Pennsylvania, 37% of CHW employers surveyed are CBOs, making them the top CHW employer in the Commonwealth (2023 PA CHW Employer Survey, n=100). Many CBOs employing CHWs do not offer health care services, but instead offer services poised to address the social determinants of health (SDOH). Self-referrals and referrals by CBO staff, including CHWs, are commonly utilized to initiate CHW services at these CBOs. To remove barriers for CBO participation in billing, CMS should allow CHI services to be initiated by CHWs and other non-medical provider types, in addition to licensed health care practitioners. CHWs are most equipped to conduct SDOH risk assessments due to their shared and lived experience and trauma-informed approach. CHW are also more likely to provide SDOH intake assessments than physicians or other health care providers.

Vulnerable beneficiaries also tend to be high ED utilizers who are not attending E/M visits or AWV, again making them most at need for CHW intervention. Several PA CHWs work in ED settings, and their initial responsibility is to administer an intake SDOH assessment to all patients. CHWs can then connect patients with valuable resources to address the needs beyond the ED, to include preventative healthcare, leading to reduced ED visits and improved overall mental and physical health. All care team members -including CHWs - should be allowed to initiate visits.

b. Same Practitioner Limitation - This rule proposes that the same practitioner conducting the initiating visit under code GXXX1 would also need to provide the follow-up CHI services under code GXXX2. CHW employers often receive CHW referrals from external entities, such as CBOs, health systems, FQHCs/RHCs, community health centers, or other health care providers. The beneficiary then undergoes a transition of care to a CHW who will address the SDOH identified in the initial setting, making it critical that practitioners outside of those initiating CHI visits can provide and bill for CHW services. Additionally, in group practice settings, one practitioner may initiate a CHI visit and another practitioner may supervise or furnish the services provided. In both examples, the individual that conducts the CHI initiating visit may not always be the same individual that provides or oversees the CHI services. We believe that limiting CHI initiating visits and CHI services to the same practitioner would create unnecessary barriers for patients, limit collaboration, and interfere with CHWs' contribution to service delivery.

c. General Supervision – The proposed rule states that "General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service." Our recommendation is to clarify or better define "general supervision" and explain what exactly is meant by CHWs being under the physician's (or other practitioner's) overall "direction and control." As stated previously, many CHWs working in CBO and community-based settings that do not provide health care services are not working under the supervision of physicians or other health care providers. To remove barriers for CBO and non-medical provider participation to provide CHI services, we are asking for clarification of this statement and a solution for how these employers would partner with health care providers to provide general supervision. CMS should provide financial incentive for health care providers to partner with

these employers to order services. See section F below for our recommendations for CBO-health care provider partnerships.

d. Ad-On Code Frequency Limit - We strongly oppose a frequency limit for CHI, PIN, and SDOH services. PA CHWs can spend an average of 4-5 hours/week per beneficiary, which includes visits, care coordination, follow-up, and the other services outlined in the GXXX1 and GXXX2 codes. To ensure Medicare equitably reimburses for and provides CHW services, CMS should not limit the number of hours that may be billed per month per beneficiary. Each beneficiary requires unique and individualized care that would be hindered by a frequency limit. CHWs initiate, build, and maintain relationships with beneficiaries to support them with their health-related goals, and these responsibilities take time. The full breadth of CHW core roles and services that can impact changes among individuals and communities are necessary to improve health outcomes at a population level. Rhode Island is one example of a state that has opted not to impose billing limits as part of their state plan amendment for Medicaid. We also recommend a 15-minute code, in addition or in lieu of the 30-minute GXXX2 code, to allow for flexibility in billing 45-minute encounters and 15-minute follow-up encounters.

e. Codes and Descriptors: – We applaud CMS for creating unique HCPC codes (GXXX1 and GXXX2) that cover the breadth of CHW services. PA CHWs believe that the proposed service descriptors accurately reflect the services they regularly provide to beneficiaries. After surveying PA CHW Employers about CHW services rendered, we found that the services identified align with the proposed descriptors. We especially applaud the recognition of leveraging lived experience "to provide support, mentorship, or inspiration to meet treatment goals" as a covered service. Based on the average amount of time it takes PA CHWs to successfully engage with beneficiaries, CMS should reimburse for all CHI services that occur within 12 months or more of qualifying visits.

d. CHI Services Valuation - The reimbursement rate for the GXXX1 one-time code is a $78.59 hourly equivalent per beneficiary, and the GXXX2 rate is a $68.76 hourly equivalent per beneficiary. We believe these rates do not reflect the amount needed for financial sustainability of the CHW workforce, nor does it reflect the Living Wage, which is the hourly rate that an individual in a household must earn to support themselves and their family. The Bureau of Labor Statistics currently identifies the mean annual wage for CHWs as $ 49,900, with the hourly wage range between $15.47 and $35.45. We recommend a range that reflects the Bureau of Labor Statistics mean salary range for CHWs and better reflects the reimbursement rate for other peer-based professionals. In addition to the cost for services rendered, we also recommend that the billing rate acknowledge the necessary operational and administrative costs for training, supervision, travel, pay increases, health care provider partnerships, and other non-billable expenses. A rate builder could be utilized for employers to determine billing rates that reflect the billable hours but also the non-billable expenses as identified above.

e. Required Training - For states that have a CHW certification program and/or state-recognized CHW training requirements, CMS should allow these states to specify who should provide the training and the number of required hours. For states that do not have a CHW certification program or state-recognized CHW training requirements, CMS should specify training content/requirements that aligns with the CHW Common Core Consensus Project (C3) competencies but not specify a required number of training hours or who should provide training. CMS should not impose a national standardized training. At least 23 states have already undertaken the arduous task of creating their own training standards, and the nuances of those training standards vary by state.

f. Barriers for Community-Based Organizations – The proposed rule appears to exclude community-based organizations and other CHW employers that are not Medicare billing practitioners and/or do not have health care providers on staff that can initiate or supervise CHW services. To participate in billing, CBOs that do not have health care providers on staff and are not billing practitioners will need to partner with a health care provider to initiate, supervise, and/or bill for services. We strongly recommend that CMS specifically outline the details and incentives for health care providers to contract with community-based organizations to initiate and furnish CHI services. We recommend an incentive for billing practitioners to partner with CBOs (e.g. a higher rate for services rendered by CHWs employed by a CBO) as there is often no organization better equipped to provide community integrated services than a CBO. To reduce barriers to CBO participation in Medicare funding, CMS should authorize a range of reimbursement rates that incentivize Medicare billing practitioners to contract with CBOs to provide CHW services. For example, the MA program in Michigan allows the managed care contracts with the state to stipulate a rate increase for CBOs that is 1.5 times the regular rate in the form of a quality pool withholding.

g. Documentation – The proposed rule states that CHI services need to be documented in an Electronic Health Record (EHR); however, many CBOs and other CHW employers do not have access to or utilize an EHR. This requirement excludes CHW employers without access to an EHR or a data sharing agreement with a healthcare provider with a EHR from participating in CHI service reimbursement. We believe that additional documentation platforms should be acceptable for this purpose.

Thank you for the opportunity to provide comments and recommendations for the CMS Physician Fee Schedule (PFS) proposed rule for calendar year 2024. Please reach out to Leanna Bird, Sustainability Committee Co-Chair at the Pennsylvania Community Health Worker Collaborative (leanna.bird@ahn.org) if you have any questions or if we can be of further assistance.

Sincerely,

Pennsylvania Community Health Worker Collaborative