Lutheran Services in America

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
Attention: CMS-1765-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: 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, etc.

Dear Administrator Brooks-LaSure:

As President and CEO of Lutheran Services in America, I appreciate the opportunity to submit comments on 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, etc. Lutheran Services in America is a network of 300 health and human services providers located in 46 states throughout the U.S. With over $22 billion in combined annual revenue, Lutheran Services in America is one of the largest non-profit networks in the U.S. caring for one in 50 Americans every year in over 1,400 communities across 45 states.

We are dedicated to advancing innovative solutions that achieve a healthier, more equitable future for millions of people in America. Through partnerships and collaboration, Lutheran Services in America leads programs that address the policy and practice changes that are needed so that all people in America can lead their best lives. We leverage our national network lens to identify trends and opportunities to scale success. Our work includes piloting promising solutions, evaluating results and sharing best practices with stakeholders across the health and human services sector.

Across our network we are committed to ensuring that members of the community are healthy and connected to the supportive services—food, social connection, transportation and mental health care—that are necessary to thrive. As more U.S. adults age, access to such services, which help address "health-related social needs," becomes even more critical to our nation's well-being. Based on our tenured experience, we offer the following comments.

Community Health Integration (CHI) Services:
We generally support CMS taking the step of recognizing the distinct impact that unmet Health-Related Social Needs (HRSNs) have on negative health outcomes and increased total cost of care, for vulnerable beneficiaries. The proposed creation of new HCPCS codes for community health integration and social determinants of health (SDOH) risk assessment is a welcomed approach for creating a pathway for providers to further integrate community health workers and community-based organizations/community care hubs in addressing HRSNs, when implementing a whole person model of care.

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 screenings during other types of visits. As a result, we recommend that CMS include the Annual Wellness Visit (AWV) and behavioral health visits in the list of qualifying medical encounters for CHI services. Physicians and nonphysician practitioners (NPPs) should be allowed to initiate CHI services during other visit types because a comprehensive wellness plan must include the impact of HRSNs on whole person care.

   When a provider creates a wellness plan, or evaluates behavioral health, 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 or housing insecurity 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 mandates the inclusion of other types of visits as initiating visits 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 as 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. Thus, transitional care management services should be explicitly included in the list of eligible initiating encounters for CHI services.

b) Role of Community-Based Organizations: As a network of community-based providers who have been working with people in our communities for decades, 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. Our providers are on the ground in their communities and have in-depth knowledge of and years of experience with available resources, in addition to the services they themselves provide.

   Safety Net providers and Physician practices that serve large volumes of vulnerable populations are often undercapitalized and may lack the infrastructure to hire additional personnel to directly deliver and supervise CHI services. These practices could leverage the option of contracting with a community-based organization, such as those in our network, to deliver CHI services. This will allow eligible Medicare providers to leverage local community assets that have detailed 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 when establishing an implementation plan for CHI services.

   Going forward, we would also urge CMS to explore expanding the types of providers who are able to directly initiate and bill for providing CHI services, to include, for example, mental health providers.

c) 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, 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 multiple HRSNs. In order to address all of them, 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. In subsequent months, there may not be the same intensity of time spent delivering CHI services. For example, the auxiliary personnel may spend less time checking the status of social care applications submitted on behalf of the beneficiary. As a result, in the subsequent months the 60-minute threshold may not be met.

Therefore, 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. As a result, we are proposing 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.

d) Consent for CHI Services: We urge CMS to finalize a consent process for CHI/Principal Illness Navigation (PIN) services which includes a verbal consent option that is documented in the clinical record and ensure the auxiliary personnel operating under general supervision can capture verbal consent in the electronic medical record. CHI and PIN services are provided as face-to-face and non-face-to-face interventions. In fact, a substantial number of CHI/PIN 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. Or, 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, such as calling assisted living facilities, memory care units, home health agencies that specialize in dementia care, and other service providers to determine if there are services available based on identified needs of the beneficiary. As such, it is imperative that there are consent options provided by auxiliary personnel that can be verbally agreed to. In addition, verbal consent should be required only once per calendar year that CHI/PIN services are required.

e) Concurrent home health plan of care: We ask that CMS allow for concurrent CHI Services while the patient is under a home health plan of care under Medicare Part B. Because many CHI services would address complex needs, they often require multiple interventions over time. During the time that CHI services are being provided, the beneficiary may require home health services. The proposal to prohibit concurrent provision of CHI services and a home health plan of care could cause a disruption in the continuity of care for addressing HRSNs because the social service component is very limited during home health services, which are generally only sixty (60) days in duration. 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 and services versus ongoing physical therapy—because it is extremely unlikely that the social service component of a limited-duration home health benefit would provide continuous social care interventions initiated by auxiliary personnel at the Medicare provider practice.

   Furthermore, 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 a 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.

f) Finalize CHI service categories that include the provision of health education and services–including services provided in group settings–to facilitate behavior change: Sound science has demonstrated the efficacy of evidence-based health education models—delivered as individual or group interventions—to support sustainable behavior changes. The Centers for Disease Control and Prevention (CDC) and the Administration for Community Living (ACL) have recognized a range of evidence-based programs that support behavior change for chronic disease self-management, fall prevention and other categories of disease self-management. Most of these health education and disease prevention programs rely on 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, which would limit access to evidence-based behavior change programs that rely on group-based interventions. Therefore, we strongly recommend that CMS create a HCPCS code for group CHI services to allow providers to implement evidence-based behavior change interventions that are recognized by CDC and ACL as effective evidence-based interventions.

g) FQHC/RHC Reimbursement for CHI / PIN Services: 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. CMS is proposing to allow FQHCs/RHCs to be reimbursed for CHI/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. However, this rationale does not reflect how auxiliary personnel, such as community health workers and

social workers, are typically paid, which is by the hour and not by the encounter.

We also strongly recommend that CMS consider a stand-alone HCPCS code for CHI/PIN 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 means these entities are likely to have a higher percentage of beneficiaries that are negatively impacted by HRSNs. Socioeconomic status and being a racial and/or ethnic minority places someone at higher 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/PIN services. The current proposed rules allow non-FQHCs/RHCs concurrent billing for CHI/PIN 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.

Social Determinants of Health Risk Assessment:

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 and identifying health-related social needs is integral to the development of a wellness plan during an annual wellness visit (AWN.) 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 AWN. 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.

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 help eligible providers develop sustainable implementation models and uplift leading practices for replication across the country.

Conclusion

We appreciate the opportunity to comment on this proposed rule and welcome any additional opportunities to share our insights and ideas towards our shared mission to empower people to live in the home and community of their choice with purpose and dignity. We look forward to building on the changes incorporated within this proposed rule to expand the ability of community-based organizations to efficiently provide services to their communities.

Sincerely,

Alesia Frerichs
President and CEO