ADVOCATES FOR COMMUNITY HEALTH

September 11, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016.

RE: File Code 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; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure:

Advocates for Community Health (ACH) is pleased to share our response to the proposed changes outlined in CMS-1784-P Medicare Physician Fee Schedule CY 2024. ACH is a membership organization comprised of leading federally qualified health centers (FQHCs) focused on health equity and innovation to drive health care systems, policies, and health programs. Our members serve over two million people in 13 states, the District of Columbia, and Puerto Rico, and provide high-quality, comprehensive primary health care, mental health services, preventive care, and social services to patients most in need.

Overall, ACH supports the CY24 Medicare Physician Fee Schedule proposals that aim to improve health equity and increase access to quality care. Below, we provide our comments on the proposed rule, addressing the following:

- **Telehealth Mental Health Visits and FQHC providers:** ACH supports and provides additional recommendations.
- **FQHCs to bill for Remote Patient Monitoring**: ACH supports.
- **Social Determinants of Health (SDoH), G2211 Code, Health-Related Social Needs Assessment and other changes**: ACH supports and provides additional recommendations.
- **Community Health Integration (CHI) services, and Principal Illness Navigation (PIN)**: ACH supports and provides further recommendations.

Telehealth, Mental Health Visits, and FQHC Providers

ACH supports implementing the telehealth provisions of the Consolidated Appropriations Act, 2023 (CAA), which include temporarily allowing the originating sites for telehealth services to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home. The rule also allows additional qualified health professionals to provide telehealth services, such as physical therapists, and the rule would delay in-person requirements for mental health visits.

ACH applauds the Fee Schedule's provision allowing and paying for Licensed Mental Health Counselors (LMHCs) and Licensed Marriage and Family Therapists (LMFTs) to provide mental and behavioral telehealth services for FQHC patients. As we commented in last year's proposed rule, allowing LMFTs and LMHCs to bill "incident to" physicians or non-physicians for behavioral health services had not been extended to FQHCs despite that the intention of the proposal was to increase access to behavioral health and advance health equity as part of the CMS Behavioral Health Strategy.[1] We appreciate that in this year's rule, parity is being extended to FQHCs so that LMHCs and LMFTs at FQHCs may bill "incident to" physicians or non-physicians for behavioral health services.

We also support the rule's provision allowing addiction counselors who meet all of the requirements of LMHCs to enroll with Medicare, further increasing resources for these patients. Uniform Data System (UDS) data for 2022 shows that over 18,000 FQHC behavioral health professionals served over 2.7 million patients with behavioral health needs, an increase of 70,000 patients from the year before. The rule's extended flexibilities increase access to behavioral health and addiction services for beneficiaries and bolster the behavioral health workforce at a time when the need is only increasing.

Additionally, in the final CY24 Medicare Physician Fee Schedule, we urge CMS to expand the FQHC visit definition (§ 405.2463) to include medical visits for telehealth and virtual services. After December 31, 2024, FQHCs will no longer be considered distant site providers that are allowed to provide telehealth services for medical visits. While we appreciate the actions contained in the rule to expand telehealth flexibility for mental health services, we hope CMS will also consider authorizing care at FQHCs for all health services in the patient's choice of modality - including but not limited to telehealth services – as a way of addressing and alleviating health disparities.

Remote Patient Monitoring

ACH supports the proposal to allow FQHCs to bill for Remote Patient Monitoring/Remote Therapeutic Monitoring under G0511. Remote patient monitoring expands access to chronic condition care management and empowers patients to take an active role in their health care, even patients with low technology literacy. Once properly implemented and integrated with electronic health records, remote patient monitoring is a sustainable solution for care management and allows community health centers to serve as true safety-net providers, especially in rural areas that benefit the most from these types of services.

[1] https://www.cms.gov/cms-behavioral-health-strategy

Health-Related Social Needs Assessment

Community health centers often act as hyper-local hubs that provide consumer driven, comprehensive care, screening for social risk factors and working to improve clinical care and quality of life for their communities. In 2022, 20% of FQHC patients screened for social risk factors reported financial strain, 13% experienced food insecurity, and 8% experienced transportation access challenges.[2]

In the CY24 Medicare Physician Fee Schedule, CMS proposes a new G code, GXXX5, for using standardized, evidence-based Social Determinants of Health Risk Assessments, such as Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE).

We strongly support this proposal but request two changes:

(1) Allow billing this code outside of E/M visits, especially during annual wellness visits and during visits with behavioral health specialists. Every encounter at a health center is a chance to assess and evaluate the patient's comprehensive circumstances that affect their mental and physical health.

(2) Clarify that FQHCs/RHCs can bill for this assessment. Currently, it is understood that the FQHC/RHC PPS does not permit separate reimbursement for other services during an E/M visit. We seek clarification that FQHCs are allowed additional reimbursement for SDOH assessment.

Community Health Integration (CHI) services and Principal Illness Navigation (PIN)

ACH applauds CMS for recognizing a beneficiary's lived experience as part of their care plan. Community Health Integration (CHI) and Principal Illness Navigation (PIN) services promote a person-centered approach to care and facilitate partnerships with community-based organizations. ACH supports billing these services under G0511, in which community health workers (CHWs) can help with health education, case management, and referrals to community resources. CHI services help address unmet SDOH needs while PIN services help beneficiaries with high-risk conditions navigate the health care system. Our members rely on CHWs from their communities, but often, the availability of CHWs is limited to open grant opportunities. Peer specialists and care navigators help facilitate treatment for cancer, substance use disorders, and other high-risk conditions.

Most importantly, we applaud the agency for allowing these auxiliary members to be contracted with community-based organizations. FQHCs often work closely with community-based organizations that can address needs outside of the scope of FQHC services.

We provide the following recommendations for CHI and PIN services:

Initial Codes and Billing Recommendations

- We recommend that the first code be allowed to be billed for the first 20-60 minutes. This increases flexibility of billing the code and meeting the needs of the patients.

[2] https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2022-trends-webinar-slides.pdf

- We also suggest allowing this code during E/M visits and annual wellness visits and allowing multiple providers to oversee and initiate the CHI visit, as health centers often work in multidisciplinary teams of behavioral health professionals, clinician providers, and non-physician practitioners.

- In addition, CMS suggests in the rule the utilization of code G0511 for CHI and PIN services. We request clarification on whether FQHCs can bill code G0511 multiple times in a single day, considering that this code encompasses various care management services. The use of distinct FQHC codes could help avoid claim denials in cases where multiple services are provided. However, in its current form, it might appear as if the billing is duplicative, especially since it is unclear if providers may bill for CHI and PIN simultaneously.

Consent and Certification

- Similar to other COVID-19 flexibilities, we recommend obtaining patient consent for these services verbally, documented appropriately, and requested no more than once per calendar year. This would reduce the administrative burden on patients and the health care team.

- We also note that many CHW services involve non-face-to-face assistance. For example, CHWs and navigators may find housing or food resources for a beneficiary. We urge CMS to count these encounters for billing purposes.

- Lastly, we advise against mandating certification for CHWs to practice. Many organizations already offer training and workforce development programs. Therefore, we advocate for leaving certification decisions to the discretion of individual states and suggest that organizations instead employ accredited, evidence-based training practices. Imposing certification requirements could unintentionally increase barriers to health care access, since obtaining certification often requires additional financial resources from many CHWs. These essential team members are trusted by the community and often link patients to other trusted local social services.

Conclusion

Thank you for this opportunity to comment. For more information, please contact me at apearskelly@advocatesforcommunityhealth.org.

Sincerely,

Amanda Pears Kelly
Chief Executive Officer