ADVOCATES FOR COMMUNITY HEALTH

September 9, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-1807-P: Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Administrator Brooks-LaSure,

On behalf of our member community health centers (CHCs) and the over 3 million patients they serve, Advocates for Community Health is pleased to share our response to the proposed changes outlined in CMS-1807-P Medicare Physician Fee Schedule for CY 2025.

Advocates for Community Health (ACH) is a membership organization focused on advocacy initiatives to affect positive change for CHCs, the patients they serve, and the entire nation's health care system. Our 38 members represent 16 states, Puerto Rico, and the District of Columbia. ACH supports the CY 2025 Medicare Physician Fee Schedule proposals that aim to increase access to quality care to beneficiaries in the community health center care setting.

Below, we provide our comments on the proposed rule, addressing the following:

- **Caregiver Training Services (CTS)**: ACH supports and seeks clarification.
- **Services Addressing Health-Related Social Needs Request for Information (RFI)**: We seek clarification on these issues and would like to work with CMS on them moving forward.
- **Federally Qualified Health Center (FQHC) Care Management**: ACH supports discontinuation of G0511, but provides additional recommendations, especially as G0511 relates to the CMS Innovation Center model flexibilities.
- **Advanced Primary Care Management Services:** ACH supports and recommends additional suggestions.
- **Advanced Primary Care RFI**: We wish to work with CMS moving forward on these issues.
- **Payment for Drugs Covered as Additional Preventive Services (DCAPS) in RHCs and FQHCs:** ACH supports.
- **Part B Preventive Vaccines for FQHCs:** ACH supports.
- **FQHC Dental Services**: ACH supports and provides further recommendations.
- **Telehealth**: ACH recommends changing the definition of a medical visit to help for payment of non-behavioral telehealth services.
- **Rebasing Prospective Payment System (PPS)**: ACH supports.

Caregiver Training Services (CTS)

ACH supports CMS' proposal to create new Healthcare Common Procedure Coding System (HCPCS) codes for direct Caregiver Training Services to support beneficiaries with ongoing conditions to reduce complications, as they are similar to CY 2024 finalized changes in the Medicare Shared Savings Program. We especially support allowing these services via telehealth. As FQHCs remain central to integrating mental and behavioral health with primary care, we also value the introduction of additional codes that support caregiver training in behavior management and modification. However, we seek clarification if these codes will be billable by FQHCs and rural health clinics (RHCs), or if they are not available to these types of providers. These codes would help our providers improve care coordination and care management.

Services Addressing Health-Related Social Needs Request for Information

As discussed in our previous CY 2024 PFS comment, our members employ community health workers, peer specialists, and care navigators to help navigate or manage treatment for cancer, substance use disorders, and other high-risk conditions. Additionally, most FQHCs screen and provide referral and care coordination around health-related social needs. We strongly support CMS' continued efforts to incentivize high-quality care for people with health-related social needs.

Currently, FQHCs use G0511 to bill for community health integration (CHI) and principal illness navigation (PIN) services, which has created challenges, including potential duplicative services and/or the mistaken denial of claims due to the appearance of duplication. In addition, it has not been clear to FQHCs how often CHI may be billed under G0511.

Therefore, we recommend that CMS take the following actions to improve services addressing health-related social needs:

- Clarify that FQHCs can bill CHI and PIN services as many times as is necessary to serve patients' needs in a given month, and at a sufficient reimbursement rate.
- Clarify, as the agency did for clinical social workers, if registered nurses and registered dietitians can also perform such services as auxiliary personnel
    - While we assume this to be the case, it would be helpful to explicitly state that these flexibilities are also applicable in FQHCs and RHCs
- Produce technical assistance materials that simplify and streamline all codes billable separate from the Medicare PPS at FQHCs

Finally, the requirement to bill co-pays to patients has decreased utilization. We strongly recommend that CMS work with the Office of the Inspector General (OIG) to create an explicit safe harbor exemption for FQHCs to waive the co-pay for all care management and health-related social needs services, and over the long-term, work with Congress to enact this exemption.

FQHC Care Management

ACH supports CMS' proposal to discontinue the use of G0511 and permit FQHCs to bill individual codes and add-on time codes. We believe that this new proposal would align better with the services provided. Additionally, the proposed approach removes current prescribed time constraints, which often force

FQHCs to provide uncompensated care because they do not consistently meet all of the billing requirements. However, we strongly recommend clear guidelines for documentation and billing purposes for when FQHCs can bill, for how much time, and how many times per month. Additionally, we strongly advocate guidance for understanding what is not allowed to be billed concurrently.

In the same vein, we encourage CMS to make similar changes to the G0512 code as they are proposing for the G0511 code. We strongly suggest that CMS allow FQHC/RHCs to utilize the 99 set of codes (99492, 99493, and 99494) when billing for Medicare patients who receive psychiatric collaborative care management (CoCM) services. We also encourage CMS to include the application of the "CPT Time Rule" otherwise known as the "50% +1 rule" to the 99 set of codes within FQHC/RHCs the same way they do for CoCM delivery to patients utilizing Medicare in other settings. Allowing FQHC/RHCs to use the 99 set of codes with the CPT Time Rule would allow for accurate capture of the work being done as well as appropriate reimbursement for the time spent. Rather than attempting to reach the minimum requirement of 70/60 minutes respectively per month, behavioral health care managers (BHCMs) could spend the clinically appropriate amount of time engaging in clinical activities and care coordination with and for the patient. This would ensure improved clinical outcomes and improved patient and provider satisfaction. In terms of billing workflow, utilizing the 99 set of codes would align with the current billing workflow for CoCM delivery for patients with Medicare, commercial coverage, and Medicaid (in states where the codes are covered) outside of FQHC/RHC settings.

Lastly, as more FQHCs enter value-based care through the Medicare Shared Shavings Program, Making Care Primary (MCP) Model, or other CMMI models, we request guidance to understand how these care management codes should be billed. As it stands, for the MCP model, G0511 is considered an eligible service for beneficiary cost-sharing reduction. If G0511 is discontinued, CMMI must need to update codes accordingly to continue allowing the cost-sharing reduction to FQHC beneficiaries. Please see more information below under the "Advanced Primary Care Management Services" section.

Advanced Primary Care Management Services

ACH supports CMS' proposal to add three new codes to encompass advanced primary care management services (GPCM1, GPCM2, and GPCM3) for FQHCs to use, but also seeks further clarification.

We do not recommend that these bundled payments include CHI and PIN services as the payment would be inadequate and the CHI and PIN provide different but complementary services. Again, if G0511 is eliminated, FQHCs would need to be allowed to bill CHI and PIN separately and distinctly in addition to these advanced primary care management codes (APCMs). Additionally, we seek clarification if there are time constraints for FQHCs, which could burden an FQHC's ability to bill these codes.

For care management codes, ACH strongly recommends direct billing guidance for FQHCs, especially since these codes allow physicians and non-physician practitioners to provide these services. Additionally, these codes cannot be billed concurrently with the above CPT codes, e-visits, virtual check-ins, or remote evaluation of patient images or videos. We appreciate the comprehensive billing, but caution the need for guidance since, as CMS states, "These new codes, they are per calendar month bundles. If the RHC/FQHC decides to bill for APCM, they would not bill for individual services."

Additionally, some FQHCs are entering the Making Care Primary model. As the model states, "Principal care management (PCM), chronic care management (CCM), and transitional care management (TCM)

services are considered duplicative of ESPs [the Enhanced Services Payment- see Appendix F], and therefore CMS will not pay participants for PCM, CCM, and TCM services furnished to attributed beneficiaries during the performance period of the model."

Lastly, as described above, our members often mention cost burden to patients. Patients often stop or drop out of treatment due to the cost-sharing burden for chronic care management. We suggest working with the OIG and Congress to allow CHCs the flexibility to waive co-pays, which aligns with their standard practice of adjusting fees based on income as guided by HRSA. Providing any help with cost-sharing would benefit the patients who need these services the most, especially if a patient receives a bill for services even though a provider has not directly seen them that month. These flexibilities are allowed in some models like MCP. Therefore, if these new codes are implemented, ACH urges CMS to examine any existing authority to permit CHCs to waive co-pays, be it working with the OIG, incorporating flexibilities from demonstration models, or working with Congress.

We also support the new cardiovascular risk assessment code to prevent chronic conditions and related complications further.

Advanced Primary Care RFI

ACH looks forward to our continued partnership with CMS to promote payment reform and move all FQHCs toward value-based care. The Advanced Primary Care Management Services is a prime example of how CMS is reforming payment to increase quality of care.

We remind CMS that FQHCs are required to provide enabling services, or non-clinical services that often improve health outcomes and quality of life, as stated under Section 330(b)(1)(A)(iv) of the Public Health Service Act. Therefore, regardless of payment setup, we recommend allowing concurrent payment of Psychiatric Collaborative Care Management service codes (CoCM) (99492, 99493, 99494) and other Chronic Care Management codes.

Additionally, we recommend CMS work with HRSA to understand Uniform Data System (UDS) requirements. This will streamline efforts across agencies and promote ways to increase health equity and reduce disparities. We often hear from our centers how FQHCs are stuck between a Value-Based Care world and Fee-For-Service world; our centers are subject to multiple regulations and different quality measures across payers.

Most importantly, we recommend a parity principle to apply the same flexibility in regulations of primary care to FQHCs or adjust regulations that account for FQHC differences. For example, in the CY 2023 Physician Fee Schedule Final Rule (CMS-1770-F), FQHCs were not included in the proposal for changes to the level of supervision for "incident to" behavioral health services for Licensed Professional Counselors, Licensed Marriage and Family Therapists. Therefore, further rulemaking was required to change regulations for FQHCs and Rural Health Clinics. This greatly affects access to care for our patients. As for flexibilities, certain practices, such as allowing FQHCs to waive chronic care management (CCM) co-pays, would be consistent with their usual practice of adjusting fees based on income, as outlined by HRSA 330 grants.

Payment for Drugs Covered as Additional Preventive Services (DCAPS) in RHCs and FQHCs

ACH supports CMS' proposed clarification that DCAPS and their additional fees are not subject to cost sharing in RHCs and FQHCs. Since DCAPS drugs and the services to administer and supply them are all considered additional preventive services, as explained in the previous section, they are paid at 100 percent of the Medicare payment amount in RHCs and FQHCs.

Part B Preventive Vaccines for FQHCs

CMS proposes allowing FQHCs bill Part B preventive vaccines and their administration at the time of service. Payments for these claims would be aligned with Part B preventive vaccine payment rates used in other settings, with an annual reconciliation based on the facilities' actual vaccine costs as reported in their cost reports. ACH supports CMS' proposal that RHCs and FQHCs begin billing for preventive vaccines and their administration at the time of service, effective for dates of service on or after July 1, 2025. ACH appreciates the additional time to make necessary operational changes.

FQHC Dental Services

In section III.B.8., CMS clarifies that when RHCs and FQHCs furnish dental services that align with the inextricably linked policies and operational requirements in the physician setting, we would consider those services to be a qualifying visit, and the RHC would be paid at the RHC AIR and the FQHC would be paid under the FQHC PPS. This would include services like dental or oral examination prior to Medicare-covered dialysis medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for beneficiaries with end-stage renal disease or medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for beneficiaries with ESRD. This would require using the KX modifier on claims for dental services inextricably linked to the covered medical services.

ACH supports and appreciates this parity in regulations. However, just as the Administration is understanding the link between medical/primary care and mental/behavioral health, we support ways in which dental health services are also part of essential primary care. In most cases, Medicare does not cover routine exams or cleanings. However, we remind CMS that FQHCs are required to provide primary health services, which as defined, include "preventive dental services".

Telehealth

As pandemic-era telehealth communication flexibilities begin to expire, ACH supports the CMS Alternative Proposal for Payment of Medical Visits Furnished Via Telecommunication Technology. We, along with RHCs, support revisiting the definition of a medical visit. Similar to NARHC's CY 2024 PFS comment, we also support incorporating medical telehealth services into the definition of a medical RHC and FQHC visit, which allows proper reimbursement for these important safety net providers. Currently, proposals do not extend provisions that allow FQHCs to bill for telehealth services and waiving in-person examination requirements for online mental health services. We urge CMS and Congress to extend and ideally make permanent the pandemic-era telehealth geography, site of service, and practitioner type flexibilities.

ACH focuses on a permanent solution such that telehealth includes interactive, real-time, audio/video telecommunication technology under the FQHC PPS. Nevertheless, we appreciate and support

temporary extensions of flexibilities, such as delaying in-person requirements for mental health services until January 1, 2026, and urge that any flexibilities extend to FQHCs and RHCs as well.

Rebasing

ACH supports CMS' proposal to rebase and revise the FQHC market basket from a 2017 base year to a 2022 base year. We also appreciate that the proposed 2022-based market basket uses a fixed-weight, Laspeyres-type price index, which will provide a reliable measure of price changes over time. This method, along with reliable data sources, ensures that the market basket accurately reflects the cost trends that FQHCs experience. Furthermore, we strongly support the inclusion of telehealth services in the 2022-based market basket, as it reflects the critical regulatory changes and the expansion of telehealth services that took place in 2022. Given the requirement for health centers to provide comprehensive services in high-need areas, telehealth has become an essential tool in overcoming geographic, economic, transportation, and linguistic barriers to healthcare access. During the COVID-19 pandemic, health centers rapidly expanded their telehealth services, with nearly 95 percent offering virtual visits. The inclusion of telehealth services in the market basket underscores its vital role in maintaining and expanding access to care, particularly in underserved communities. This update is a crucial step in ensuring that FQHCs continue to meet the evolving needs of their patients.

Exclusion of 340B Acquired Units from Part D Rebatable Drug Requirements

ACH supports CMS' proposal to use an estimation approach to exclude 340B acquired units from Part D rebatable drug requirements, as it imposes the least burden on FQHCs. We do not believe a claims data repository is necessary in addition to this proposed approach.

Conclusion

We appreciate the opportunity to provide feedback on Medicare policies and payment. For more information, please contact me at apearskelly@advocatesforcommunityhealth.org and/or Stephanie Krenrich, our Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org.

Sincerely,

Amanda Pears Kelly
Chief Executive Officer

Advocates for Community Health