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

September 11, 2023

RE: ***Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2024***

Dear Administrator Brooks La-Sure,

On behalf of IMPaCT Care (IMPaCT), we thank you for the opportunity to offer comments on proposed CMS-1784-P, regarding revisions to payment policies under the Medicare Physician Fee Schedule Quality Payment Program and other revisions to Part B for calendar year 2024.

We commend CMS on taking landmark steps to create a more community-based, person-centered Medicare program through the creation of new codes for Community Health Integration (CHI) services.

Community Health Workers (CHWs) are trustworthy people who come from within the communities they serve. They get to know their patients as people and provide holistic, tailored support based on individual needs and preferences. Evidence-based CHW programs improve outcomes, reduce costs, and address the urgent crises in American health care today: inequity and clinical workforce shortages. Medicare coverage for CHI services has the potential to be transformative, increasing access to these vital services in a way that drives value, reduces disparities, and unlocks greater workforce capacity.

IMPaCT is the leading evidence-based intervention in the U.S. for addressing health inequity and the social determinants of health; it is used by over 50 organizations across 20 states. IMPaCT has been tested in multiple randomized controlled trials and found to improve chronic disease control, mental health, and quality of care while reducing total hospital days and returning $2.47 for every dollar invested. We are deeply appreciative of CMS's vision to advance Community Health Integration and the ways in which it aligns with IMPaCT best practices, developed and refined through rigorous science conducted in partnership with more than 70,000 patients over 15 years. In this letter, we offer a number of specific comments and recommendations to refine the proposals with an eye toward equity and health improvement.

IMPaCT Care Comments

1. **Requiring an Initiating E/M Visit from a Billing Practitioner**

Because beneficiaries who most need CHWs are least likely to have stable primary care, we support the ability for a wide variety of practitioners to conduct the CHI-initiating visit across multiple encounter types. Specifically:

- We are seeking clarification on whether the full range of qualified health professionals permitted to bill E/M codes are permitted to bill the GXXX1 code.
- We strongly support additional professional services other than an E/M visit to qualify as the prerequisite initiating visit for CHI services, including the Annual Wellness Visit (AWV).
- We encourage the agency to consider alternative referral pathways to allow hospitalized patients to be referred to CHI services. We recommend that a practitioner who identifies an SDOH need – for example, a physician treating a patient in the Emergency Department who is experiencing food insecurity – be permitted to refer to a CHW for both a comprehensive assessment and ongoing CHI services. That patient's primary care provider could provide the general supervision necessary for the CHW. This will help to ensure that Medicare beneficiaries who end up in the hospital – in part because they don't have an engaged primary care provider willing/able to refer them to a CHW – will have an opportunity to access the benefits of CHI services.
- We urge the agency to reconsider its proposal to exclude home health patients from receiving CHI services. The focus of home health services is more clinical in scope; thus, home health personnel are not a replacement for CHW services. CHWs, unlike home health aides, are members of the communities they serve, hired based on trust-building traits like empathy and non-judgment. The training and workflows of a CHW are also distinct from home health teams; CHWs get to know their patients as people and provide holistic tailored support. Since patients who receive home health care also often face social risk, allowing CHWs to deliver CHI services to home health patients will make a significant difference in health outcomes and overall cost savings.

2. Initiating, Ordering, and Supervising CHI services

We applaud CMS for the services included in GXXX1, particularly for placing a strong emphasis on a person-centered assessment, self-advocacy skills, and leveraging lived experience. We support the structure that CMS proposes, whereby the billing practitioner conducts an E/M visit that identifies SDOH need(s) that limit the ability to diagnose or treat the problem(s), and subsequently orders CHI services. We appreciate that CMS has established that CHI services may be billed by no more than 1 practitioner monthly in order to maintain a longitudinal care relationship.

We commend CMS for applying the general supervision standard to these services, under which the practitioner's direction, but not their presence, is required during the performance of the service. This arrangement is critical to allow for CHWs and other eligible providers to provide services outside of the clinical setting and in the community where patients feel trusted and protected.

We are seeking clarification on two issues:

- We recommend that CMS clarify that the initiating visit and GXXX1 are distinct and may represent two separate clinical encounters. Our understanding based on the proposed rule is that the "initiating visit" is a prerequisite for CHI services, but would not typically be the same as the CHI assessment and goal-setting visit (GXXX1). This is critical, because the initiating E/M visit would typically be performed by a billing practitioner, and the CHI intake (GXXX1) may be performed by auxiliary personnel under the general supervision of the billing practitioner.
- Our understanding, which we recommend CMS clarify, is that the services delivered must address the need identified, but are not limited *only* to the services initially recommended in the initiating visit. In the course of a comprehensive person-centered assessment and goal-setting (including the patient's life story, strengths, needs, goals, preferences, and desired outcomes, as well as incorporating cultural and linguistic factors), there is a strong likelihood that a CHW would identify other needs and patient preferences that relate to the treatment plan. In the proposed rule, CMS provided an example in which "The patient's primary care practitioner (PCP) learns during a clinic visit after discharge from the ED, that the patient has been able to reliably fill their prescriptions for diabetes medication, but frequently loses the medication (or access to it) while transitioning between homeless shelters and a local friend's home…To accomplish the treatment plan, the PCP orders CHI services to develop an individualized plan for daily medication adherence/access while applying for local housing assistance." CHI services may identify additional needs and goals that also limit the practitioner's ability to treat the problem (e.g., domestic violence not documented in the initiating visit that also impacts the patient's ability to maintain hemoglobin A1c within appropriate levels). We recommend that, as long as general supervision requirements are met (e.g., the CHW is regularly updating the billing practitioner on CHI services provided), the practitioner is not required to create a new order or conduct a new initiating visit.

3. CHIs Service Settings, Frequency, and Duration

Thank you for the opportunity to provide comments on the modality, frequency, intensity, and duration of CHW services. The following recommendations are based on evidence-based CHW programs:

- <u>Modality:</u> Effective CHW programs center the person and engage them in an ongoing action plan to address patient goals, providing a range of tailored supports: social and emotional support, health care access/health system navigation, resource connection, health motivation, and advocacy. The services delivered within a given session or over the course of a month can vary based on both urgent needs and long-term patient goals. One session could take place in person, the next over the phone, and then a CHW could accompany the patient to an important appointment. It is critical that CHI services be accessible across all delivery modes and to maintain accessibility for rural populations and/or individuals with limited broadband. However, programs with the strongest evidence do include some in-person interaction. In order to incentivize this in-person

interaction, we recommend that CMS provide a higher payment rate for services delivered in person than for services delivered virtually.

- Frequency: Effective CHW interventions require ongoing engagement to establish trust and to address complex issues at the intersection of health needs, social needs, community context, and an individual's life history. A watered-down approach that involves infrequent interaction with a patient is unlikely to lead to the outcomes that have made evidence-based CHW programs successful. It is critical that billing GXXX2 be permitted at least weekly. Therefore, we strongly oppose a frequency limit for the add-on code. In addition, we recommend at least one in-person interaction each month, unless the patient is in an area designated as rural, frontier, tribal, or geographically isolated territory.
- Intensity: Performing the initial visit, including assessment and goal-setting for people with complex health and social needs, frequently takes 90 minutes to complete in a way that establishes trust and a strong foundation of ongoing engagement and problem resolution. For this reason, we recommend a payment value of $132 (in person) or $88 (virtual including telephone). In terms of ongoing support intensity, programs with the strongest evidence deliver an average of 90 minutes per week, building trust by achieving regular progress on the issues most important to the patient.[1] We re-iterate our concern about any frequency limit to the add-on code; the ability to spend adequate time with patients will be essential for high-quality CHI service provision.
- Duration: The duration of support by a CHW can vary depending on client characteristics. Programs with the strongest evidence for return on investment have had a 6-month duration.

4. Training and Certification Requirements

We appreciate that CMS sought comment on training requirements. We agree with CMS that there is a strong need to ensure CHI services are high-quality and consistent with evidence-based best practices. We respectfully disagree that the best way to achieve this aim is through an individual training requirement for auxiliary personnel. Of all of our comments provided in this letter, this is the most important issue to address in order to ensure that Medicare beneficiaries receive high-quality CHW services that effectively improve outcomes.

Individual certification programs, common across other health care systems, are often the path of least resistance and relatively simple to implement. Unfortunately, a study funded by the Agency for Health Research and Quality (AHRQ) found that these requirements do little to improve quality.[2] In fact, these requirements may have unintended consequences. A recent study of the effects of state certification policies found that they may entrench pay inequities, raising wages for white male CHWs yet having no significant effect on wages for CHWs of color

[1] Kangovi S, Mitra N, Grande D, Huo H, Smith RA, Long JA. Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial. Am J Public Health. 2017 Oct;107(10):1660-1667. doi: 10.2105/AJPH.2017.303985. Epub 2017 Aug 17. PMID: 28817334; PMCID: PMC5607679.

[2] Ibe CA, Wilson LM, Brodine J, et al. Impact of Community Health Worker Certification on Workforce and Service Delivery for Asthma and Other Selected Chronic Diseases. Rockville (MD): Agency for Healthcare Research and Quality (US); March 2020.

and women, who make up the majority of the workforce.[3] Training and certification requirements may also weed out many natural helpers who may not be able to afford the fees or navigate the burdensome bureaucratic requirements of certification. By requiring these training programs, the CHW workforce is at risk of being co-opted by individuals who are not from within the communities they serve, do not share lived experiences with their patients, and just "check the box" of training.

There is an alternative approach to ensuring CHW program quality that is being implemented by a growing number of state Medicaid agencies: program-level accreditation for organizations that employ CHWs. Accreditation is based on best practices for domains such as hiring, training, workflows, and supervision. Professional groups such as the Community Based Workforce Alliance[4] and National Committee for Quality Assurance (NCQA)[5] have developed recommendations for program-level standards in partnership with CHWs. These best practices for CHW programs include recruitment of CHWs based on their lived experience, fair compensation, career ladders, adequate training and supervision, the use of person-centered workflows with reasonable caseloads, and processes for protecting CHW safety. It is important to note that these domains encompass, but are not limited to, training. The C3 project, which developed the core consensus model for CHW roles and skills, has evolved in this direction as well.[6]

There is a risk that if the proposed rule stands as written ("In States where there are no applicable licensure or other laws or regulations relating to individuals performing CHI services, we are proposing to require auxiliary personnel providing CHI services to be trained to provide them"), it may have an unintentional chilling effect on states currently developing program-level accreditation. CMS has the authority to allow program-level accreditation to supercede individual-level certification. For example, hospitals meeting Joint Commission Standards are "deemed" as having met Medicare's Conditions of Participation. We note that the Medicare home infusion therapy benefit provides one example of successful accreditation standards driving quality. Home infusion therapy must be furnished by a qualified supplier, and URAC's Medicare Home Infusion Therapy Supplier Accreditation includes a comprehensive assessment of standards and practices that ensure quality and accountability.

<u>Given the evidence of negative impacts of certification on equity and the growing movement toward program-level accreditation, we strongly recommend that CMS 1) announce its intent to undertake a formal process to approve accrediting organizations for programs employing CHWs/billing CHI codes; or 2) signal that it intends to review program-level accreditation standards as they become available, with the potential for them to serve as an effective</u>

---

[3] Jones TM, Jeung C, Schulte A, Lewis CM, Maddox PJ. Hourly Wages and Turnover of Community Health Workers According to US State Certification Policy and Medicaid Reimbursement, 2010–2021. American Journal of Public Health. 2022 Aug 10(0):e1-9.
[4] Community Based Workforce Alliance, Advancing CHW Engagement in COVID-19 Response Strategies. February 2021. Available online https://nachw.org/wp-content/uploads/2021/09/CWBA-Playbook-11421.pdf.
[5] National Committee on Quality Assurance, "Critical Inputs for Successful CHW Programs." November 2021. Available online: https://www.ncqa.org/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW-Programs-White-Paper-November2021.pdf
[6] CHW Common Indicators Project: Proposed Indicators for Priority Constructs. Available online https://www.chcf.org/wp-content/uploads/2021/05/CHWPsMediCalRsrcPkg3CIProposedIndicatorsPriorityConstructs.pdf

substitute for individual-level training requirements. The accreditation option could also provide a default in states that do not have state laws or regulations relating to the training or certification of CHWs as otherwise required.

If in the end, CMS chooses to proceed with an individual training requirement for auxiliary personnel, we at least recommend that it have the following elements:

1) **Accessibility**. CHWs should not have to pay for training, nor should they have to travel or take significant time out of existing employment. Initial CHW training within an evidence-based model can be completed in 60 hours.
2) **Focus on upstream topics**. We support the competencies that CMS included in the proposed rule that align with the C3 project (patient and family communication, interpersonal and relationship-building, patient and family capacity-building, service coordination and system navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including of local community-based resources). CHWs are not trained clinicians or health educators, and the training should not focus on clinical topics.
3) **Respectful and appropriate to the role.** CHWs bring significant skills and expertise (including their lived experience and empathy) to a role that requires substantial flexibility and person-centeredness. A didactic style training does not prepare them for their work in the field. Training should instead be based on principles of popular education and adult learning.
4) **Development-oriented.** Training shouldn't be a one-time certification. It should be ongoing and support professional development to facilitate CHW career ladders.
5) **Team-based.** Training should also exist for supervisors, not just CHWs themselves. CHWs do their best work within a team-based care ecosystem that supports their contributions.

We do not believe it is appropriate to name specific organizations to provide the training in the final rule. CMS could undertake a process by which training providers are selected and endorsed, as with the accreditation process we propose above.

5. EMR Integration and Documentation

We appreciate the importance of incorporating CHI services in the medical record as a critical source of information on the patient's health and care, as well as to ensure appropriate billing. We are concerned that the requirement that CHI services are appropriately documented in the medical record may be interpreted as a requirement that the auxiliary personnel themselves must document in the medical record, which could pose a significant barrier to CHWs employed by community-based organizations (CBOs) – many of whom may be best positioned to "meet patients where they are," bringing shared lived experience and trust to the relationship. Our understanding, which we recommend CMS clarify, is that services must be documented in the medical record by the billing practitioner, but not necessarily by the auxiliary staff delivering the services. This arrangement would allow a CBO to communicate with the billing practitioner about the services provided (including the time spent furnishing services and the social needs

addressed) without requiring CBOs to have the technical capacity to directly input into medical records.

6. **Medicare Cost-Sharing and Beneficiary Consent**

We appreciate CMS's attention to patient consent, particularly given limitations on CMS's authority to waive cost-sharing for CHI services. Although CHWs may provide services working either directly with or indirectly on behalf of the beneficiary, the majority of CHI services involve direct patient engagement or, at minimum, communication to update the patient. Although we believe that CHI services should not be delivered without direct patient contact at least weekly, we nonetheless recommend that verbal patient consent be required, similar to requirements for chronic care management. Verbal consent establishes a foundation of trust and respectful communication, solidifying the relationship necessary to implement an action plan to address patient goals. It also will avoid surprise bills due to cost-sharing requirements, particularly given that the average length of proven CHW services is 6 months.

7. **State Medicaid Coverage of CHI Services**

We do not find CMS' proposal duplicative with current Medicaid coverage of services to address the social determinants of health, nor those services delivered by CHWs. Several states have pursued Medicaid coverage for addressing the social determinants of health, but more often, are taking a piecemeal approach - tackling housing or food insecurity. Medicare's proposal takes a more effective holistic approach to identify and remedy all social determinants of health impacting a beneficiary's medical condition.

In a July 2022 survey of states, over half of responding states (29 of 48) reported allowing Medicaid payment for services provided by CHWs. In states that do provide some coverage of CHW services, the mechanism by which they are paid varies widely; some states have added benefits through State Plan Amendments, others as elements of 1115 waivers, and others through arrangements with their Medicaid Managed Care plans. Services can be limited to just a few narrowly defined codes, restricting the CHW's ability to address all social determinants of health impacting the patient. None of these states allow billing for a more intensive initiating visit, as in this Medicare proposal. Permitting Medicare reimbursement for the types of CHI services included in the proposed rule can complement and strengthen any services currently being provided under Medicaid. In addition, half of states have no coverage for services provided by CHWs.

Thank you again for the opportunity to provide comments on these proposed rules. We look forward to continuing to collaborate with CMS on these critical issues. For any questions or to request more information, please contact Dawn Alley at dalley@impactcarehq.com.

Sincerely,

Shreya Kangovi
CEO, IMPaCT Care