

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1784-P
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21224-1816

RE: 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; Continued Implementation of Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; and Medicare Advantage

Dear Administrator Brooks-LaSure:

[Civitas Networks for Health \(“Civitas”\)](#) appreciates the opportunity to provide input on CMS 1784-P; Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Free Schedule and other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Continued Implementation of Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; and Medicare Advantage (“Proposed Rule”). Civitas is a national nonprofit collaborative comprised of more than 165 member organizations—health information exchanges (HIEs), regional health improvement collaboratives (RHICs), and providers of services to meet their needs—working to use data frameworks, information infrastructure, and multi-stakeholder, cross-sector approaches to improve health for individuals and communities. We educate, promote, and influence both the private sector and policymakers on matters of interoperability, quality, coordination, and cost-effectiveness within the health system.

While many areas of this Proposed Rule overlap with Civitas’ work and the activities of our members, we take particular interest in the following topics:

1. CHI and PIN Service Descriptors

Civitas applauds CMS’ decision to continue to build on its decade-long streak of progressively expanding support for chronic care coordination, care management, and transitional care services through the Medicare program by proposing a new set of coding and payment policies for Community Health Integration (CHI) and Principal Illness Navigation (PIN) activities performed by trained auxiliary personnel working under the auspices of a billing practitioner. These clinical staffers—including but not limited to community health workers (CHWs)—are on the front lines of the transition to value-based care in tens of thousands of primary and specialty care practices nationwide, identifying obstacles to effective treatment for many of the most vulnerable, medically complicated, and systemically expensive patients and working persistently to remove them. Specifically recognizing the time and effort required to help high-need patients negotiate the complex challenges arising from social determinants of health (SDOH) and manage multi-faceted, prolonged, and often dynamic plans of care for severe illnesses is not only necessary to more accurately account for the work that clinical teams are already doing, but to further

incentivize physicians to make sustained CHI and PIN activities a priority and institutionalize such work as an integral aspect of care delivery at the ground level of the health care system where it has the greatest impact.

Accordingly, the Proposed Rule includes two new G-codes and official descriptors for 60 minutes of baseline CHI services each month plus 30-minute blocks of additional CHI services as needed, while two new G-codes and descriptors for PIN services use the same structure. CHI services are described as patient-centered assessments of “psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors,” which are addressed by “communication with practitioners, home-and-community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities)” and by “coordinating receipt of needed services from health care practitioners, providers, and facilities; home and community-based service providers, social service providers, and caregivers” in such a way as to enhance both the quality of the patient’s care and their own self-efficacy. PIN services are similarly described as patient-centered assessment and multi-service coordination (including “coordination of care transitions between and among health care practitioners and settings” and “facilitating access to community based-social services”), though this activity is intended to take place in the context of individualized treatment for specific “high-risk, serious illnesses” such as “cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.”

What neither descriptor makes any reference to is *how* this communication, coordination, and facilitation will take place—which, if CMS wants to continue promoting health system modernization at scale, will necessarily involve health information exchange and data management on the part of the trained auxiliary personnel. CHWs and staff in similar roles vary widely in the extent of their day-to-day knowledge and experience with health data systems, reflecting the differences that exist among providers in integrating these systems into their practices more generally. While more than three-quarters of physicians now use some form of EHR platform for coding and medical recordkeeping, much of the real power of health IT in terms of efficiency and cost-effectiveness is in larger cross-cutting functionality that includes interoperable, multi-directional synchronous or near-synchronous clinical data sharing, data treatment and quality control, and connected referral networks to address individualized needs at the local and regional levels.

These are the functions that Civitas member HIEs and RHICs bring to practitioners who leverage them for CHI and PIN services in their current under-reimbursed form. As separate billable activities under Medicare, CHI and PIN services that explicitly cover health data functions would improve service quality for patients and providers; push CHW training and certification to place more emphasis on health data applications; and further drive the adoption of health information technology across primary care. Therefore, Civitas is recommending that CMS revise its descriptors for the new CHI and PIN services in the Proposed Rule to recognize health data management and health information exchange functions. For instance, the descriptors could read “communication with practitioners, home-and-community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) *through the use of secure, multi-functional and platform-agnostic health information exchange networks*” or “facilitating access to community-based social services *through local stakeholder-driven, secure data sharing networks and specialized care coordination and referral systems.*”

2. CHI, SDOH Risk Assessment, and PIN Service Structure

The new CHI and PIN services described in the Proposed Rule bookend another activity that CMS plans to G-code separately from its wider care coordination portfolio for the first time: the Social Determinants of Health Risk Assessment (SDOH risk assessment), comprising a patient-centered “review of the individual’s SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions.” Notably, practitioners and auxiliary personnel performing the assessment would not be required to use one of CMS’ in-house social needs methodologies (like the Accountable Communities tool or the Medicare Advantage Special Needs Population Health Risk Assessment tools), and would instead have the freedom to conduct their assessment using any approach that is “standardized, evidence-based...tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.” Civitas applauds this flexibility as an asset that will facilitate implementation, given that many (though not all) of our member organizations have built their existing SDOH evaluative capabilities and clinical partnerships around the Protocol for Responding to & Assessing Patients’ Assets, Risks and Experiences (PRAPARE) tool (which the Proposed Rule also explicitly mentions as an option).

One area where the proposed CHI, SDOH risk assessment, and PIN services appear to be less flexible is CMS’ plan to require E/M “initiating visits” with the billing practitioner for each Medicare patient before the trained CHW or other auxiliary staffer can take over day-to-day care coordination responsibilities. While Civitas understands that the agency must operate within the bounds of the Medicare Benefit Policy Manual as it interprets them, we nonetheless want to underscore how inefficient and potentially counterproductive a narrow “physician-first” reading of the “incident to” rule would be in these cases, especially given the Proposed Rule’s broad reading of “clinical integration” as flexible “oversight” of third-party auxiliary personnel and community-based organizations (CBOs) by the billing practitioner. We contend that CHI, SDOH risk assessment, and PIN services can and should be thoroughly integrated into the billing practitioner’s operations without the practitioner having to act as “gatekeeper” for these services in all cases.

Many of Civitas’ RHIC member organizations that have worked extensively with CHWs as liaisons and coordinators in primary care settings know from experience (backed by a large body of public health research) that they are most effective as the primary points of contact with patients from the initial consultation through every subsequent encounter, communication, and follow-up, in and out of the doctor’s office. To engage the most chronically underserved, health-illiterate patients who are often the most averse to regular contact with clinical personnel, the CHW must be front-and-center in every interaction—including the first interaction and evaluations—in order to build and maintain trust that is vital on both the individual and community levels. Under the “closed loop” care coordination model that is aligned with “patient-centered medical home” best practices endorsed by CMS and other authorities, the CHW is expected to take a proactive role in developing and implementing comprehensive patient social needs assessments; incorporating the findings into the overall care plan; and ensuring documentation through the relevant health data platforms before a supervisor is directly involved. The model places a premium on structuring CHW work as outreach to high-need, high-risk individuals where they are, connecting them to primary care homes before they are forced into contact with the health care system by a serious or chronic illness, and negotiating barriers to care access or adherence that would otherwise go unaddressed.

Consistent with this model, Civitas recommends that the Proposed Rule be revised to maximize the ability of supervisors and practitioners to review and code the billable work of their auxiliaries at any point during the patient and community engagement process, rather than tethering much of the social needs and patient navigation reimbursement enterprise to the initial E/M visits with the practitioner as a pre-requisite for payment. Allowing Annual Wellness visits furnished by physicians or other types of enrolled health professionals to take the place of E/M visits for CHI, SDOH and PIN purposes—which the Proposed Rule raises as a possibility in the course of discussing the structure of PIN services—would likewise create more flexibility in how these activities are carried out. In the same vein, we also recommend that CMS adjust the service times and frequency limits proposed for all three new care management code sets to better reflect the resource investment of auxiliary personnel and their partners in and out of clinical settings, per the agency’s specific request for comment on the issue. For context, many CHWs engaged by Civitas’ RHIC members average between one and three hours per month on each patient, including assessment and coordination activities (but not including patients in high-need specialty care areas like maternity or serious mental illness), which suggests that the supplemental 30-minute CHI and PIN blocks in the Proposed Rule be revised upward.

3. Coding for SDOH Risk Assessment

According to the Proposed Rule, CMS intends to use ICD-10 Z codes Z55-Z65 to document the findings of patients’ Medicare-billed SDOH risk assessments in the medical record and on claims. This usage is consistent with the agency’s other recent reporting on social, economic, and environmental factors known to affect health and health-related outcomes, and includes ten different issue descriptions that cover the four social determinant factors specifically referenced in the rulemaking (food insecurity, housing insecurity, transportation needs, and utility difficulties) directly or indirectly. Civitas views the use of Z codes for the new SDOH risk assessment service as a necessary start, but far from the end state on social needs documentation given the proliferation of new and more precise code sets and associated data standards being developed and tested by payer and provider organizations across the country. Civitas itself is an implementation partner in the Gravity Project for HL7 FHIR social determinant standards via grant funding from the Robert Wood Johnson Foundation, working alongside Project sponsors that include national commercial payers, medical associations, ONC and CMS (among other stakeholders). The Gravity standards are currently being piloted for public health and equity use cases in Arizona, Oklahoma, Colorado, and New York with the aim of demonstrating efficacy for wider deployment. A number of Civitas members who also incorporate the NCQA HEDIS Social Needs Screening and Intervention (SNS-e) measures into their work the as a function of partnerships with commercial payers would benefit from CMS accounting for these measures in the Proposed Rule.

On behalf of Civitas and our members, thank you again for the opportunity to comment on CMS-1784-P and for your consideration of our recommendations. We would also like to draw your attention to comments from individual Civitas members which have been submitted separately in response to this Proposed Rule, and which further articulate unique perspectives and priorities based on extensive experience in their respective service areas. The Civitas community is deeply engaged in multiple corners of the health data policy and regulation space, and we stand ready to collaborate to achieve our shared goal of creating a higher-value health system.

Please do not hesitate to reach out if you have any questions or comments for us.

Sincerely,



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