September 11, 2023

Submitted electronically via regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: 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 (CMS-1784-P)

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to provide comment on the *Fiscal Year 2024 Medicare Physician Fee Schedule proposed rule.* We appreciate and applaud your continued efforts and commitment to ensuring providers and payers participating in federal health care programs have the tools and resources to better understand and take steps to address individuals' health and social needs.

Aligning for Health is an advocacy organization that brings together a broad coalition of members focused on improving health and wellbeing through interventions related to better aligning health and social needs. We are supported by an Advisory Board of individuals representing public health, mental health, housing, community development, human services, and many other sectors. As a coalition, we work to develop and promote actionable, bipartisan policies that create opportunities - and remove challenges - for states and local governments, health care organizations, and non-health care organizations to work together to develop cross-sector, coordinated solutions to address both health and social needs.

As CMS and the Assistant Secretary for Planning and Evaluation (ASPE) have noted, roughly 50 percent of an individual's health is impacted by social determinants.[1] The conditions or environments that we inhabit, including our communities, our homes, our access to healthy foods, education, employment, and transportation, all impact our health and use of health care services.[2] Surveys have found that respondents who self-report poor health and higher health care utilization, and who experience high inpatient or ER utilization, are more likely to report multiple unmet social needs.[3]

Unfortunately, our current health and social services programs and systems - as well as their underlying infrastructure - function largely independently of one another, making efforts to address health and social needs, including coordination of care and services, data sharing, and financing difficult to achieve. These challenges serve to further strain the safety net and place additional burdens on the people it serves.

Health care providers, health systems, and payers alike have begun taking steps to better identify individuals' social needs and risk factors, and to build connections with social service providers and

[1] https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/
[3] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/insights-from-the-mckinsey-2019-consumer-social-determinants-of-health-survey

community-based organizations (CBOs) to provide referrals and to coordinate care. However, sufficient and sustained reimbursement and incentives to identify and build partnerships to address health-related social needs are needed to ensure such activities become and remain a common part of health care treatment and support. Moreover, CBOs need sustained partnership and financial support to develop the capacity and infrastructure to continue to address individual and community social needs.

Therefore, we strongly support CMS' efforts through this proposed rule to incorporate a Social Determinants of Health (SDOH) Risk Assessment in the Medicare Annual Wellness Visit (AWV) and to create new billing codes for clinicians and their auxiliary personnel that provide services addressing health-related social needs.

We applaud CMS' actions not only to provide reimbursement for screening for social needs, but also to encourage and support providers and other entities in taking steps to address identified social needs and perform social care coordination through the Community Health Integration (CHI) and Principal Illness Navigation (PIN) services. Performing screenings without equipping providers with the tools and capacity to share and make closed-loop referrals to available resources or provide self-navigation resources may unintentionally increase provider burden and risk patients' trust. We also strongly support CMS' goals in allowing and encouraging providers to partner with CBOs and community health workers (CHWs) in delivering CHI and PIN services – creating vital linkages that can support and improve outcomes.

However, while we strongly support CMS' overarching vision and proposals, we also raise several implementation concerns below in considering how these proposals would work in practice.

Finally, while we support adding these new services and codes under the Medicare fee-for-service program, we encourage CMS to continue to align across programs, models, and initiatives to the extent possible on screening and social care strategy requirements. Differing avenues and model requirements necessitate separate workflows and infrastructure, which places burden on not only on practitioners but also for community-based organizations, community health workers, and other partners that seek to work together to address health and social needs. We also encourage CMS to actively advance and expand the use of value-based care models that provide flexibility in use of care teams and accountability for improved outcomes within the Medicare program.

Social Determinants of Health Risk Assessment in the Annual Wellness Visit

CMS is proposing to add an SDOH Risk Assessment as an optional add-on service to the Medicare AWV with no cost sharing on the part of the beneficiary. Under this proposal, the Assessment would be furnished as part of the same visit and on the same date of service as the AWV, so as to inform the care the patient is receiving during the visit, including taking a medical and social history, applying health assessments and prevention services education and planning.

Aligning for Health strongly supports the addition of an SDOH Risk Assessment as an optional, additional element of the AWV. Identifying social needs as part of the AWV will allow a practitioner to concurrently evaluate all health and social needs and to work with the beneficiary, consistent with their goals and preferences, to develop a comprehensive plan of care to address any identified needs.

Services Addressing Health-Related Social Needs

CMS proposes five new codes to describe and separately value three types of services that may be provided by auxiliary personnel incident to the billing physician or the practitioner's professional services, and under the billing practitioner's general supervision, when reasonable and necessary to diagnose and treat the patient: CHI services, SDOH risk assessment, and PIN.

Aligning for Health is strongly supportive of CMS' proposals to provide reimbursement to providers to screen for health-related social needs and to provide social care coordination services for individuals with identified social needs or with acute conditions.

Although CMS has begun to include quality measures focused on social needs screening in several of its payment programs, screening for social risk or social needs information by providers is not commonly performed. While providers may want to address their patients' social needs, they do not always have the tools, capacity, or resources. According to a survey by the Physicians Foundation, nine in 10 physicians want to address patients' social drivers of health, but six in 10 lack the time and ability to do so.[4] Surveys of providers have found that financial resources and incentives, and time, are most often cited as barriers to screening.[5]

As CMS notes, providers may currently receive some additional reimbursement for collecting social risk factor information under evaluation and management (E/M) coding guidelines.[6] However, dedicated resources are invaluable in building capacity for screening and referrals, and ensuring availability and access to resources to support whole-person care.

Importance of Screening and Documenting Identified Social Needs in a Standardized Way

Aligning for Health supports CMS' efforts to improve documentation of identified and standardized social needs information. Comprehensive, standardized, and timely data is a key component to successful care coordination and to connect individuals to needed services to address their health and social needs.

Documenting social needs data in health records and promoting greater exchange of such data will equip providers with a more comprehensive view of the factors affecting an individual's health. Moreover, social risk and social needs data can be leveraged to provide insights into best practices and drivers of health disparities. As a 2020 HHS Report to Congress on Social Risk Factors in Performance in Medicare's Value-Based Purchasing Program noted, "beneficiary social risk information is not routinely or systematically collected across the health care system, and there is not always standardized terminology to capture beneficiary social risk information."[7] Further, a 2021 CMS report on the utilization of Z codes for social determinants of health found that social needs data had only been collected and reported to CMS for 1.59 percent of Medicare beneficiaries, a fraction of the likely population with social needs.[8]

CMS has since issued guidance to encourage the use of Z codes to capture SDOH information, but CMS' proposals in this rule will serve to provide stronger awareness and reimbursement for screening and documentation of social needs information, which will help to support more holistic efforts to improve health outcomes.[9,10]

We also support the administration's efforts to improve the interoperability of social needs information, a critical element of cross-sector care coordination. Documentation and exchange of data will also help providers to understand whether social needs have already been identified, thus reducing duplicative and potentially harmful screenings. We urge CMS to align requirements for screening and documentation across programs and models to simplify implementation.

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[4] https://physiciansfoundation.org/wp-content/uploads/2017/12/Drivers_of_Health_Care_Costs_-_November_2012.pdf
[5] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2751390
[6] https://www.ama-assn.org/practice-management/cpt/social-determinants-health-and-medical-coding-what-know
[7] https://aspe.hhs.gov/system/files/pdf/263676/Second-IMPACT-SES-Report-to-Congress.pdf
[8] https://www.cms.gov/files/document/z-codes-data-highlight.pdf
[9] https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf
[10] https://www.cms.gov/files/document/zcodes-infographic.pdf

Over the past few years, CMS and HHS have also made strong investments and taken significant steps to promote and require interoperability and exchange of health data, including social determinants of health data. For example, we applaud efforts by the Office of the National Coordinator for Health IT (ONC) to incorporate social determinants of health data into the U.S. Core Data for Interoperability (USCDI) version 2, and CMS' use of ONC's data standards in its interoperability regulations.

We also support and applaud the work of several HHS agencies in their efforts to advance the concept of community care hubs, which can help to facilitate social care coordination and data sharing efforts.[11]

Improving Partnerships with Community Based Organizations

Aligning for Health applauds CMS for providing sustainable funding to better connect the health and social services sectors and ensure that funding can flow where the referrals are going to support CHI and PIN services. These investments to connect health care entities and social services organizations can help to reimburse CHWs and CBOs for their time and resources and understand the true cost of, and where such organizations are successful in, addressing basic needs.

It is vitally important for CMS to continue to consider ways to bolster CBO capacity, including by providing CBOs with support and assistance in navigating health care partnerships and in addressing data sharing exchanges.

Partnerships with CBOs and trusted community partners such as CHWs or other health care supports help to close gaps in care and focus on more upstream challenges, which leads to improved outcomes. CBOs are uniquely positioned to address hard-to-reach, community-level factors of daily life that drastically impact health outcomes. These trusted organizations embedded in local communities best understand the root causes of these issues in their communities and the local resources available to address them. This expertise allows CBOs to work with clients to mitigate the impact of SDOH factors, thus improving the efficacy and efficiency of physicians' care plans.[12] In fact, extensive research indicates that CBOs' innovative solutions for high-risk populations experiencing SDOH lead to fewer hospital readmissions.[13] However, many CBOs do not have expertise or experience in contracting with health care entities, and may benefit from guidance outlining best practices.

We note that successful and seamless social care coordination will require CBOs and other entities to have the technical capability and capacity to seamlessly share data and participate in financing arrangements with health care organizations. Unfortunately, social service organizations and CBOs have not benefitted from the same level of infrastructure and systems funding and support as health entities have. Many CBOs do not have the capacity to invest in the tools and functionality required to connect with individual primary care providers or other entities that would allow for sufficient clinical integration, which may include seamless closed-loop referrals, billing and invoicing for their services delivered, and data exchange. We encourage CMS to consider opportunities and collaborate with other agency partners, to also support the development of CBO infrastructure needed to support social care coordination.

Additionally, statewide and regional efforts to connect health care organizations and CBOs for purposes of electronic referrals, outcomes tracking, electronic resource directories, and care coordination may help to bridge some gaps. As HHS officials note in their description of community care hubs (CCHs),[14] integrated

[11] https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs

[12] https://journals.sagepub.com/doi/pdf/10.1177/109019810202900302?casa_token=k5NSkPSiRSIAAAAA:gRnxGHgWrNlu8NI8bfb7sVR06FbZ8rGrfYXgn08_rL8pNJvf2Cy6BbelPhAlp1xqr28XBFaZ9_wb

[13] https://www.sciencedirect.com/science/article/pii/S2352827322001082

[14] https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs

hub or network models, including social care networks, can bring together CBOs, private foundations, health care organizations, and technology vendors to provide a common point of connection and resources, alleviating the burden of multiple one-off contracting, training, connections and exchanges. Coordinated networks also provide users with greater insight into resource availability and allocation across health and social services providers. CMS should continue to promote and work with Congress to catalyze further development of such integrated, collaborative networks across the country, in addition to payment models that help to advance such efforts.

Vital Role of Community Health Workers

Aligning for Health strongly supports CMS' efforts to acknowledge and support the work of CHWs through these proposals. CHWs have played[15] a vital role at the community-level in bridging workforce gaps and serving as trusted community partners who provide essential health and social services. CHWs are non-clinical, frontline health care professionals who reside in the communities they serve. CHWs and CBOs also tend to be reflective of and share lived experiences with those in the communities they serve. As such, they are in a unique position to reach community members where they reside and should be leveraged as trusted community partners that can bridge care gaps and improve health outcomes.

CHWs and CBOs provide a range of culturally appropriate services to address the health and social needs of the community they serve. This can include[16] translation services, health education and information, informal counseling and guidance on health behaviors, and providing direct services such as screenings for blood pressure or first aid. CHWs and CBOs can also play a role in advocating[17] on behalf of patients, particularly when engrained in a health care system, to bridge the relationship and build trust between patients and their clinicians. Recent evidence[18] has indicated the value of CHWs in reducing health disparities, improving health outcomes, advancing health equity[19] and addressing health-related social needs, and helping individuals access health care in traditionally underserved areas.

Education & Support for Providers

Aligning for Health appreciates CMS' consideration of the importance of training for auxiliary personnel providing CHI and PIN services. We agree that training should include "competencies of 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." Such competencies are invaluable in ensuring that individuals performing CHI and PIN services have the skills and expertise to manage and navigate complex and highly personal individual and community situations.

We also recommend CMS consider providing education and technical assistance for billing practitioners, to help them to understand the value and importance of asking and documenting information on social risk and social needs, and to ensure they have the tools, partnerships, or resources available to furnish CHI and PIN services, as needed.

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[15] https://www.nhlbi.nih.gov/health/educational/healthdisp/role-of-community-health-workers.htm
[16] *Id.*
[17] https://www.nejm.org/doi/full/10.1056/NEJMp2022641
[18] https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/
[19] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2782746

Operational Questions & Concerns

Below, we provide additional comments and raise questions regarding the operationalization of these proposals.

- **Incident to Billing Requirements** – While we applaud CMS' efforts here to provide a pathway for CHWs or other personnel employed by CBOs to furnish services under Medicare, and support the implementation of General Supervision requirements, we are concerned that the proposed incident to billing requirements may be complex to administer and may not provide sufficient, direct reimbursements to CHWs and CBOs for their services.
    - Under this proposal, CHWs and CBOs would receive payment for services rendered via their contract with the billing practitioner. It is unclear whether this process will result in CHWs and CBOs receiving adequate reimbursement for their time and services. To ensure that contracts with CBOs adequately consider sufficient payments for services stemming from SDOH Risk Assessment referrals, CHI services, and PIN services, CMS should consider issuing guidance and technical support to encourage sufficient payment to CHWs and CBOs for their time and services delivered.
    - Additionally, given that the CHW's power is its role in the community, we are worried that this proposal could inadvertently lead to consolidation and integration of CHWs and other auxiliary personnel into clinician practices, where payment may be more robust. Additionally, CMS' proposal encourages practitioners to contract with CBOs and ensure "sufficient clinical integration," which may create additional burdens and barriers to CBOs and CHWs to comply with independently.
    - We also urge CMS to consider how community care hubs or social care networks that help to bring together health care provider practices with CBOs and CHWs would fit under the proposed incident to billing framework.
- **Scope of CHI and PIN Services** – While we applaud CMS' innovation in proposing these two new services, we urge CMS to consider additional flexibilities beyond just social care coordination, to also provide reimbursement and support for activities to address social needs. Since Medicare payment generally is limited to items and services that are reasonable and necessary for the diagnosis or treatment of illness or injury, we encourage CMS to consider to what extent CHI and PIN services could support treatment of illness or injury that may be exacerbated by nutrition, transportation or housing instability by, for example, paying for meals or transportation, subject to appropriate guardrails.
- **Cost Sharing for Individuals** – We appreciate CMS's efforts not to require patient consent before administering CHI and PIN services as a way to reduce barriers to care, though this decision must be appropriately weighed against the financial burden of receiving care. We are concerned with proposals that contemplate cost-sharing requirements for beneficiaries, especially for a beneficiary population facing health-related social needs, and urge CMS to consider ways to eliminate or substantially reduce the cost-sharing burden for beneficiaries receiving these services. Notably, Healthy People 2030 points out that financial instability is a primary SDOH,[20] thus new services must be considered through an access perspective. We note that the Center for Medicare and Medicaid Innovation plans to waive cost sharing for certain beneficiaries

[20] https://health.gov/healthypeople

receiving services similar to CHI and PIN through the new Making Care Primary model.[21] We encourage CMS to consider opportunities to apply similar flexibilities for the broader Medicare population.

- **Data Collection** – We support CMS' proposed documentation requirements for these codes, including encouraging the documentation of what activities are being performed by auxiliary personnel. However, we encourage CMS to consider what other information might be necessary to evaluate the impact and outcomes resulting from these new services (e.g., have the identified social needs been addressed) without imposing additional burdens on clinicians.
- **Evaluation** – We encourage CMS to consider how it intends to evaluate the impact of these new proposals, whether assessing the effect on beneficiary outcomes (e.g., reduced ED visits or hospitalizations), lower costs, or simply the number of claims billing for GXXXX1-5. Documentation requirements will provide a rich source of data for CMS to understand and to share with stakeholders whether certain interventions are performed more regularly than others, which have an impact on beneficiary outcomes and/or cost, and whether there are best practices moving forward in continuing to iterate on these policies.

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Thank you again for the opportunity to provide comments on this important issue. Please do not hesitate to let us know if you have any questions. I can be reached mquick@aligningforhealth.org.

Sincerely,

Melissa Quick

Co-Chair, Aligning for Health

[21] https://innovation.cms.gov/media/document/mcp-rfa