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CY2024 Physician Fee Schedule Proposed Rules for Addressing HRSNs Overview

Timothy P. McNeill, RN, MPH

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Comment Period

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Available:

- https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched
- Comments due no later than 5pm on September 11, 2023
- Comment submission methods
  - In commenting, please refer to file code CMS-1784-P.
  - Comments, including mass comment submissions, must be submitted
  - 1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov
  - Follow the "Submit a comment" instructions.

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Key Sections Addressing Health Equity

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- Social Drivers of Health (SDOH) Screening
- Community Health Integration (CHI)
- Principal Illness Navigation (PIN)

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Social Drivers of Health Screening

SDOH Risk Assessment Valuation

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- Billed as part of a E/M Visit
- “We propose a direct crosswalk to HCPCS code G0444 (Screening for depression in adults, 5-15 minutes), with a work RVU of 0.18, as we believe this service reflects the resource costs associated when the billing practitioner performs HCPCS code GXXX5.”
  - Reference Point: CY2023 National Rate for G0444 = $18.64
- “Therefore, we are proposing to add this code to the Medicare Telehealth Services List to accommodate a scenario in which the practitioner (or their auxiliary personnel incident to the practitioner’s services) completes the risk assessment in an interview format, if appropriate.”

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Request for Comment

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- "CMS is seeking comment on **whether we should require as a condition of payment for SDOH risk assessment that the billing practitioner also have the capacity to furnish CHI, PIN, or other care management services**, or have partnerships with community-based organizations (CBO) to address identified SDOH needs."
- **My Comment:** FQHC/RHC PPS does not allow for separately reimbursable services delivered during the time of a E/M visit for the same beneficiary. As a result, FQHCs/RHCs would not receive additional reimbursement for performing the SDOH Risk Assessment during a scheduled E/M visit.
  - Labor would be captured in coding but not separately reimbursed

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Community Health Integration (CHI) Services

Community Health Integration Billing Codes

- We are proposing to create two new G codes describing CHI services performed by certified or trained auxiliary personnel, which may include a CHW, **<u>incident to</u>** the professional services and under the **<u>general supervision</u>** of the billing practitioner.
- We are proposing that CHI services could be furnished monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit.

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Initiating Visit Requirement

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- We propose that the CHI initiating visit would be an E/M visit (other than a low- level E/M visit that **can be performed by clinical staff**) performed by the billing practitioner who will also be furnishing the CHI services during the subsequent calendar month(s).
- The CHI initiating visit would serve as a pre-requisite to billing for CHI services, during which the billing practitioner would assess and identify SDOH needs that significantly limit the practitioner's ability to diagnose or treat the patient's medical condition and establish an appropriate treatment plan.

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Use of Auxiliary Staff such as CHWs

- The subsequent CHI services would be performed by a CHW or other auxiliary personnel incident to the professional services of the practitioner who bills the CHI initiating visit.
- The same practitioner would furnish and bill for both the CHI initiating visit and the CHI services, and CHI services must be **furnished in accordance with the "incident to" regulation at § 410.26.**

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Contracting with Community-Based Organizations

- We are proposing that a billing practitioner may arrange to have CHI services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the "incident to" and other requirements and conditions for payment of CHI services are met.
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Clinical Integration Requirement

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- While we are proposing to allow CHI services to be performed by auxiliary personnel under a contract with a third party, we wish to be clear, as we have in our regulations for current care management services, that there must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided, and the connection between the patient, auxiliary personnel, and the billing practitioner must be maintained.
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Incident To Requirements

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- For purposes of assigning a supervision level for these "incident to" services, we are proposing to designate CHI services as care management services that may be furnished **under the general supervision** of the billing practitioner in accordance with
- § 410.26(b)(5). General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but **the physician's (or other practitioner's) presence is not required during the performance of the service** (§ 410.26(a)(3)).

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Types of Services covered under CHI

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- Specifically, we are proposing that **SDOH(s) may include but are not limited to food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities, when they significantly limit the practitioner's ability to diagnose or treat the problem(s)** addressed in the CHI initiating visit.
- Since Medicare payment generally is limited to items and services that are reasonable and necessary for the diagnosis or treatment of illness or injury, the focus of CHI services would need to be on addressing the particular SDOH need(s) that are interfering with, or presenting a barrier to, diagnosis or treatment of the patient's problem(s) addressed in the CHI initiating visit.

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Time Based Billing Codes

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- GXXX1 Community health integration services **performed by certified or trained auxiliary personnel, including a community health worker**, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit:
- GXXX2 – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to GXXX1).

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Comment Items

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- "We are also seeking comment on **whether we should consider any professional services other than an E/M visit performed by the billing practitioner as the prerequisite initiating visit for CHI services**, including, for example, an annual wellness visit (AWV) that may or may not include the optional SDOH risk assessment also proposed in this rule. Under section 1861(hhh)(3)(C) of the Act, the AWV can be furnished by a physician or practitioner, or by other types of health professionals whose scope of practice does not include the diagnosis and treatment involved in E/M services, for example a health educator."
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Comment Items (Cont.)

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- We are proposing to require that time spent furnishing CHI services for purposes of billing HCPCS codes GXXX1-2 **must be documented in the patient's medical record** in its relationship to the SDOH need(s) they are intended to address and the clinical problem(s) they are intended to help resolve.
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Comment Items (Cont.)

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- We are seeking public comment, in particular, regarding **whether we should require patient consent** for CHI services. (Page 246)
- As we have frequently discussed in prior rulemaking for care management services (for example, at 81 FR 80240), **we do not have statutory authority to waive cost sharing** for care management or other services. (Page 246)
- However, **if we hear from public commenters that CHI services would frequently not involve direct contact with the patient**, or could extend for periods of time for which the patient might not be expecting to incur cost sharing obligations (such as multiple months), **we would consider requiring patient consent** to receive CHI services in our final rule. (Page 247)

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Concurrent Billing

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- We are proposing that **the practitioner could separately bill for other care management services during the same month as CHI services**, if time and effort are not counted more than once, requirements to bill the other care management service are met, and the services are medically reasonable and necessary.
- **We propose that CHI services could not be billed while the patient is under a home health plan of care under Medicare Part B**
  - **Page 249**
- **My Comment:** A person with food or housing insecurity would lose their CHI services when they have a home health need. Home health services generally extend for 60 days. This would cause the provider and the beneficiary to have to choose between Housing/Food assistance and home health services.

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Request for Comment

- We also seek comment on **whether there are other service elements not included in the proposed CHI service codes that should be included,** or are important in addressing unmet SDOH need(s) that affect the diagnosis or treatment of medical problems, where CMS should consider coding and payment in the future.
- **My Comment:** Chronic Disease Self-Management science supports group interventions. There is no pathway for group interventions under the current proposed rules. Group services would require a different HCPCS code. Evidence-based chronic disease programs in group settings would not be covered under the current proposal.

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CHI Valuation

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- Proposed CHI Services Valuation
- For HCPCS code GXXX1, we are proposing a work RVU of 1.00 based on a crosswalk to CPT code 99490
  - CY2023: **CPT 99490 National Rate = $60.15**
- FQHCs/RHCs
  - We note that under the proposals to expand the billable services under HCPCS code G0511 to include CHI and PIN
  - In section III.B.4.b and c. of this proposed rule, we are proposing to expand the billable services under HCPCS code **G0511 to include RPM, RTM, CHI, and PIN**. (Page 468)
  - **My Comment:** One code represents a range of care management services listed above.

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Additional FQHC/RHC Billing Implications

- Proposed FQHC/RHC Rate G0511 = $72.98 (Page 473)
- under HCPCS code G0511, **we do not include the add-on HCPCS codes payable** under the PFS because **RHCs and FQHCs do not pay their practitioners based on additional minutes** spent by practitioners. Instead we generally include the base codes. (Page 468)
- **My Comment:** This policy is based on practitioners not being paid hourly at FQHCs/RHCs. CHWs are paid hourly and not based on an encounter, so should the same logic apply?

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FQHC/RHC Care Management Policy Reference

- CFR Vol. 82, No. 219, Wednesday, **November 15, 2017**, Page 53172
- Link: https://www.govinfo.gov/content/pkg/FR-2017-11-15/pdf/2017-23953.pdf
- 3. Proposed Care Management Requirements and Payment for RHCs and FQHCs

"(We note that GCCC1 and GCCC2 were placeholder codes and are **replaced by G0511 and G0512**"

"This code [G0511] could only be billed **once per month per beneficiary**, and could not be billed if other care management services (such as TCM or home health care supervision) are billed for the same time period."

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Care Management Rates for FQHCs

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- FQHCs use different codes for care management services. There is a flat rate for FQHCs and the rate does not vary by geography.
- Rates

HCPCS Code	Description	Rate
G0511	General Care management (20 minutes/month)	**$77.94**
G0512	Psychiatric Collaborative Care (70 minutes the firs month; 60 minutes/subsequent month)	**$146.73**

- There is no provision to allow for additional calendar month billing of care management services for FQHCs/RHCs (one fixed flat payment per month per beneficiary)
- CMS Policy Link: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center

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Principal Illness Navigation (PIN) Services

Proposed Service Definition

- For CY 2024, we are proposing to better recognize through coding and payment policies when certified or trained auxiliary personnel under the direction of a billing practitioner, **which may include a patient navigator or certified peer specialist,** are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected **to last at least 3 months**, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.

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Target Populations

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- Examples of serious, high-risk diseases for which patient navigation services could be reasonable and necessary could include cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.

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Intervention Defined

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- Proposed Principal Illness Navigation (PIN) Service Definition
- PIN services could be furnished following an initiating E/M visit addressing a
- serious high-risk condition/illness/disease, with the following characteristics:
- One serious, high-risk condition expected to last at least 3 months and that
- places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death;
- The condition requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.

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Auxiliary Personnel operating Incident To the Physician

- The subsequent PIN services would be performed by auxiliary personnel incident to the professional services of the practitioner who bills the PIN initiating visit. The same practitioner would furnish and bill for both the PIN initiating visit and the PIN services, and PIN services must be furnished in accordance with the "incident to" regulation at § 410.26.
- We would not require an initiating E/M visit every month that PIN services are billed, but only prior to commencing PIN services, to establish the treatment plan, specify how PIN services would help accomplish that plan, and establish the PIN services as incident to the billing practitioner's service.

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Request for Comment - PIN

- We are also seeking comment on **whether we should consider any professional services other than an E/M visit performed by the billing practitioner as the prerequisite** initiating visit for PIN services, including, for example, an annual wellness visit (AWV) that may or may not include the optional SDOH risk assessment also proposed in this rule.

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Request for Comment (Additional items)

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- "Similar to CHI services (discussed previously in this proposed rule), we believe that many of the elements of PIN services would involve direct contact between the auxiliary personnel and the patient, but may not necessarily be in-person and a portion might be performed via two-way audio.
- We are seeking to confirm our understanding of where and how PIN services would be typically provided (**for example, with or without direct patient contact, in-person, using audio-video, using two-way audio; and whether navigators are typically local to the patient**)."

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PIN Consent

- We are seeking public comment in particular regarding **whether we should require patient consent for PIN services.**

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Concurrent Billing

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- "We are proposing that the practitioner could bill separately for other care management services during the same month as PIN, if time and effort are not counted"
- In section III.B.4.b and c. of this proposed rule, **we are proposing to expand the billable services under HCPCS code G0511 to include RPM, RTM, CHI, and PIN.** (Page 468)
- **My Comment:** G0511 for FQHCs/RHCs would not allow for concurrent billing because all of care management services are bundled into one code and only one encounter can be billed per beneficiary per month.

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Review of the Chronic Care Management Codes

Chronic Care Management – 2023 National Rates

CCM

- G0506: Chronic Care Management Care Plan (1 time per annum) = $59.26
- 99490: First 20 minutes (Non-complex) = $60.15
- 99439: Each subsequent 20 minutes (Non-complex) = $45.46
- **Rate for 1 hour (Non-complex) = $151.07 per patient per month**
- 99487: Complex Chronic Care Management (60 Minutes) = $127.18

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ASPE Analysis of CCM/TCM Utilization

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- ASPE Report on the 2019 utilization of CCM and TCM by eligible Medicare beneficiaries:

Exhibit 2: Medicare FFS Beneficiaries Receiving CCM or TCM Services in 2019

Category	CCM	TCM
Total Medicare FFS beneficiaries with Part B coverage	35,598,051	35,598,051
Number of FFS beneficiaries potentially eligible for CCM or TCM	22,570,404	6,282,242
Percent of FFS beneficiaries potentially eligible for CCM or TCM	63.4%	17.7%
Beneficiaries with one or more CCM or TCM claims	882,728	1,078,580
Percent of potentially eligible beneficiaries with CCM or TCM claims	4.0%	17.9%

https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf

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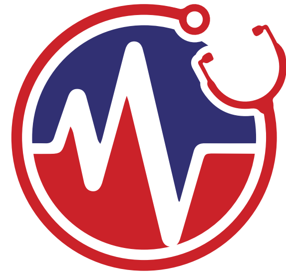

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Thank You

811 L Street, SE
Washington, DC 20003

202-344-5465

tmcneill@freedmenshealth.com