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What Does the CY 2024 Medicare Physician Fee Schedule Proposed Rule Mean for Addressing HRSNs?

August 22, 2023 | 1:30-3:00 p.m. ET

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Administrative Notes

- ✓ This webinar is being recorded. The recording, slides, and follow-up material will be shared with all registrants
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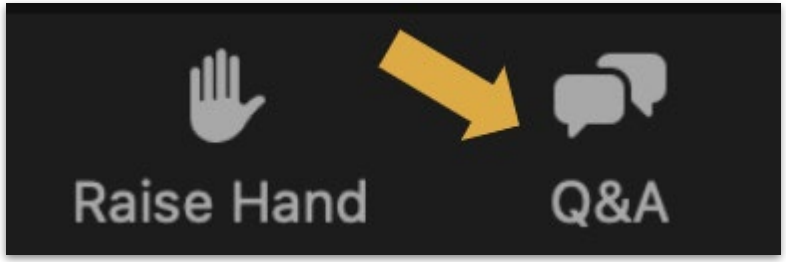

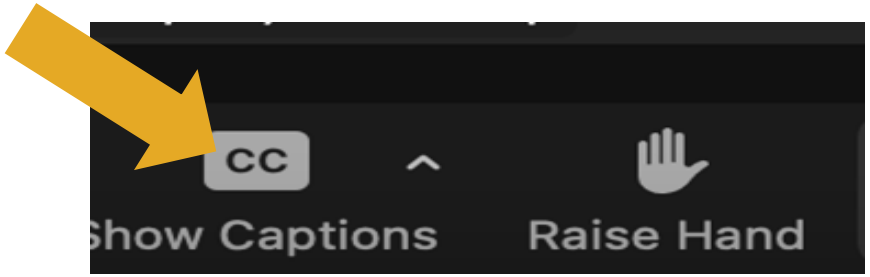

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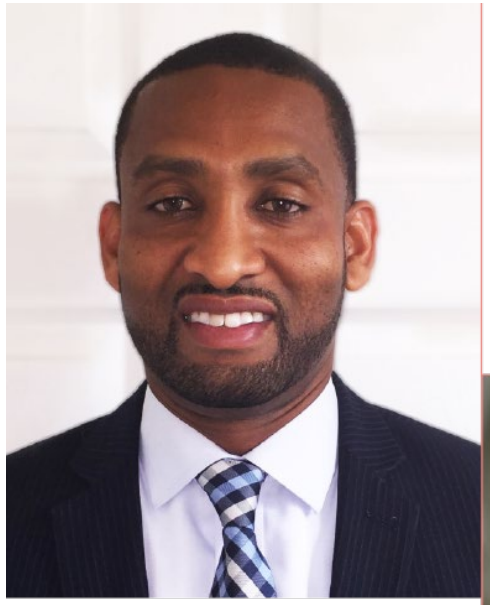

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Today's Agenda

1. Welcome and Introduction

2. Overview of proposed CY 2024 PFS, implications for addressing HRSNs, and opportunities to weigh in

3. Q&A

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Partnership to Align Social Care

Mission:

To enable successful **partnerships** and contracts **between health care and community care networks** to **create** efficient and sustainable **ecosystems** needed to provide **individuals with holistic, person-centered social care** that demonstrates cultural humility.

Vision:

A **sustainably resourced, community-centered social care delivery system** that is **inclusive** of all populations and **empowered by shared governance** and financing, multistakeholder accountability, and federal/state/local policy levers.

Co-Designing a Social Care Delivery System

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Implementing Co-Designed Social Care Delivery System Changes

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Current Partnership CCH Resources

- Working with Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies
- Community Care Hub Primer: Background, Evolution, and Value Proposition of Working with a Local CBO Network Led by a Community Care Hub
- Slide Deck: Evolution of the Community Care Hub Model to Align Social Care with Healthcare
- Functions of a Mature Community Care Hub

Partnership to Align Social Care Webinar Series

- Cultivating Community Care Hubs, An Evolving Model to Improve Alignment between Health and Social Care Services (slides)
- Integrating Community Care Hubs into Efforts to Address SDOH: A Playbook for State Medicaid Agencies (slides and additional resources)
- Leveraging Multi-Payer Partnerships with Community Care Hubs to Build Equitable Health and Social Care Ecosystems (slides)

Webinar Series: Leveraging Community Care Hubs to Foster Health and Social Care Alignment

- Leadership, Governance, and Business Development
  - Slides & Recording Available
- Contract Administration & Compliance and IT & Security
  - Slides & Recording Available
- Network Recruitment, Engagement, and Support
  - Slides & Recording Available

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Pending Partnership Resources

Community Care Hub Workgroup	Contracting Workgroup	Billing/Coding Workgroup
• Talking about equitable health and social ecosystems: A guide for clear and effective language • A screening tool for communities (new/existing CCHs) and guidance to resources, tools, best practices, and opportunities for growth. • Written documentation of the stakeholders & recommendations to formally recognize and promote the development of networks led by qualified CCHs: by advocacy/policy, hospitals/health plans/health systems, associations, foundations, and community	Four-Part Series: • Partnerships with community-based organizations: Opportunities for health plans to create value • A Health Plan's Guide to Paying CBOs for Social Care • Operationalizing contracts: Methods payers can employ to improve collaboration with community-based organizations • Developing the scope of work Other Potential Resources • Template contracts and annotated guides to contracting • A report summarizing the major findings and recommendations of the working group, including recommendations for implementation support	• Health Related Social Needs Care Coordination Labor and Direct Interventions list for Coding • Environmental scan of the current landscape of billing codes to support interventions to address Health Related Social Needs • Guiding principles for EDI operations and operations and interoperability needs for CBO networks

CY2024 Physician Fee Schedule Proposed Rules for Addressing HRSNs Overview

Timothy P. McNeill, RN, MPH

August 22, 2023

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Comment Period Open

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Available:

https://www.govinfo.gov/content/pkg/FR-2023-08-07/pdf/2023-14624.pdf

- Due Date: September 11, 2023, 5pm EST
- 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
  - 2. Mail (See Sample Comments for mailing address)

Key Sections Addressing Health Equity

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

SDOH Risk Assessment

SDOH Risk Assessment HCPCS Code

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- We [CMS] are proposing a new stand-alone G code, GXXX5, Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.
- We [CMS] are proposing GXXX5 to identify and value the work involved in the administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit.

SDOH Risk Assessment Required Elements

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- We [CMS] further propose that the SDOH risk assessment must be furnished by the practitioner on the same date they furnish an E/M visit, as the SDOH assessment would be reasonable and necessary when used to inform the patient's diagnosis, and treatment plan established during the visit.
- Required elements include: Administration of a standardized, evidence-based SDOH risk assessment.

SDOH Risk Assessment Tools

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- CMS Accountable Health Communities tool.
  - https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
- Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool.
  - https://prapare.org/the-prapare-screening-tool/
- Instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.

SDOH Risk Assessment Valuation

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- "We [CMS] 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 [CMS] 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."

Request for Comment items

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- Should CMS 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
- Should the SDOH Risk Assessment be covered as part of services besides an E/M encounter, such as an Annual Wellness Visit.

Community Health Integration (CHI) Services

Community Health Integration Billing Codes

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- We [CMS] are proposing to create **two new G codes describing CHI** services performed by certified or trained auxiliary personnel, which may include a CHW, **incident to** the professional services and under the **general supervision** of the billing practitioner.
- We [CMS] 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.

Time Based Billing Codes for Social Care Labor

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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).

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).
- [My Comment]: In many primary care settings, including FQHCs/RHCs, physicians and non-physician practitioners (Physician Assistants and Nurse Practitioners) operate as care teams. This is particularly true in health professional shortage areas (HPSAs). As a result, the beneficiary may be seen by more than one provider in a group practice, but each provider adheres to a shared care plan within the group practice.

Use of Auxiliary Staff such as CHWs

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- 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.**

Contracting with Community-Based Organizations

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- We [CMS] 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.
  - Page 247

Clinical Integration Requirement

- While we [CMS]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.
  - Page 247

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)).

Types of Services covered under CHI

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- Specifically, we [CMS] 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.
- "…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."
  - Medical Necessity [My Comment]

Comment Items

- "We [CMS] 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)…"
  - Page 238

Comment Items (Cont.)

- 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.
  - Page 245

Comment Items (Cont.)

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- We [CMS] 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 [CMS] do not have statutory authority to waive cost sharing** for care management or other services. (Page 246)
- [My Comment]. CHI Services frequently occur when a CHW or auxiliary personnel are working on behalf of the consumer without direct face-to-face contact.

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.

Request for Comment

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- We [CMS] 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.

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.

Additional FQHC/RHC Billing Implications

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- 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. The primary workforce for CHI/PIN are CHWs and Navigators, which are generally paid on an hourly basis and not based on an encounter. I would urge CMS to reconsider the option for time-based billing given the primary workforce is paid on an hourly basis and additional expenses would be incurred based on more time spent.

FQHC/RHC Care Management Policy Reference

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- Federal Register, Vol. 87, No. 222/Friday, November 18, 2022. Rules and Regulations. Page 69736.
- …if the requirements for each of these care management services are met, then HCPCS code G0511 can be billed more than once in a calendar month
- [My Comment]: While it is assumed that the G0511 code will allow for more than one claim to be submitted per calendar month for the delivery of CHI and PIN services, it is not clear if more than one G0511 encounter can be billed on the same day for the same beneficiary.

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**

- [My Comment]: CMS has established a precendent for creating a new HCPCS code for a separate care management service as indicated by HCPCS code G0512

Principal Illness Navigation (PIN) Services

Proposed Service Definition

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- 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.

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**.

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.

Auxiliary Personnel operating Incident To the Physician

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- 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.

Request for Comment - PIN

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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 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.
- [My Comment]: Cognitive assessments and Advanced care planning are already part of the AWV. PIN specifically includes dementia and other conditions that would be identified and addressed in an AWV.

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. [Consent or no consent]
- [My Comment]: Example – PIN services for advanced dementia would include reviewing care options in the community (ALF, Homecare, Memory Care Units) to first determine availability and appropriateness, which would not be done directly with the patient but instead working on behalf of the patient).

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:** Clarification required to determine if FQHCs can be paid for the same beneficiary on the same day given the range of services that are bundled into one code (G0511).

Review of the Chronic Care Management Codes

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

Process Flow Model / Sample Interventions

Community Care Hub = CHI/PIN Implementation Model

Consumer Negatively Impacted by Social Drivers of Health (food, housing, Transportation, etc.)

Physician/NPP Completes SDOH Risk Assessment GXXX5 as part of E/M Encounter

CCH acts as Single Point of Referral for a Network of CBOs deploying a CHW workforce delivering CHI/PIN for providers across a market/region

CBO/CHW completes a Comprehensive, Evidence-Based SDOH Screen

CCH Team Develops a CHI/PIN Person-Centered Plan to Health-Related Social Needs(GXXX1)
CBO integrates plan with Physician/NPP in EMR

CCH Works to Blend & Braid *All Available Resources* to Address Identified Needs:
Public + Private + Healthcare + Philanthropy
GXXX1/G / GXXX2 (add on)

CCH incorporates CHI/PIN interventions and outcomes documentation into EMR as a Closed-Loop Referral w/ Z-Codes

CCH + Part B Provider CQI:
Health Impact: Health-Related Social Needs trends, HEDIS Gaps closed, Total Cost of Care
Process measures: Referral Volume, # Engaged, Collections/Sustainability, Return on Investment (ROI)

Sample Community Health Integration Interventions

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Food Insecurity

- Enrollment in SNAP
- Amazon Prime
  - SNAP makes a person eligible for a free Amazon Prime membership
  - SNAP/EBT can be used to purchase food on Amazon that is delivered to the home
- Walmart+
  - Shop EBT-eligible groceries online & have them delivered right to your door from your local store.
  - Free membership for persons enrolled in SNAP.

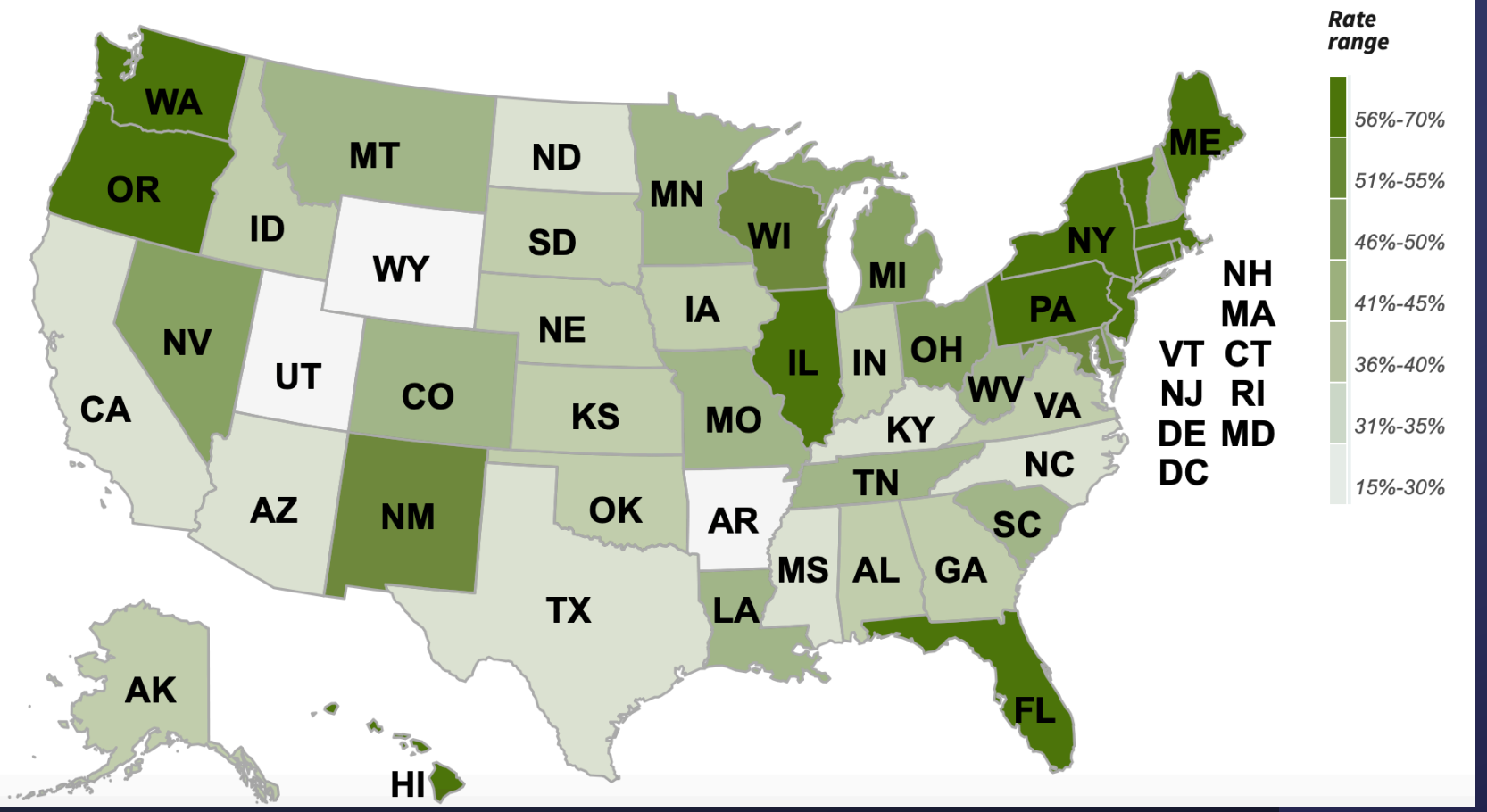
Housing/Income Insecurity

- Medicare Part D Subsidy
  - 150% FPL: Expanded eligibility for the "Extra Help" program as part of the Inflation Reduction Act, effective Jan. 1, 2024.
- HUD Coordinated Entry / Continuums of Care (CoCs)
- HUD 202/811
- CDBG Utility Assistance
- Money Follows the Person
- Medicaid Waiver (Duals – Medicare + Medicaid)
  - Home Delivered Meals
  - Personal Care Aide
  - Homemaker Services / Home Modifications

USDA Food and Nutrition Service
U.S. DEPARTMENT OF AGRICULTURE

SNAP Participation Rates by State, Elderly People (FY 2018)

National Rate: 42



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Thank You

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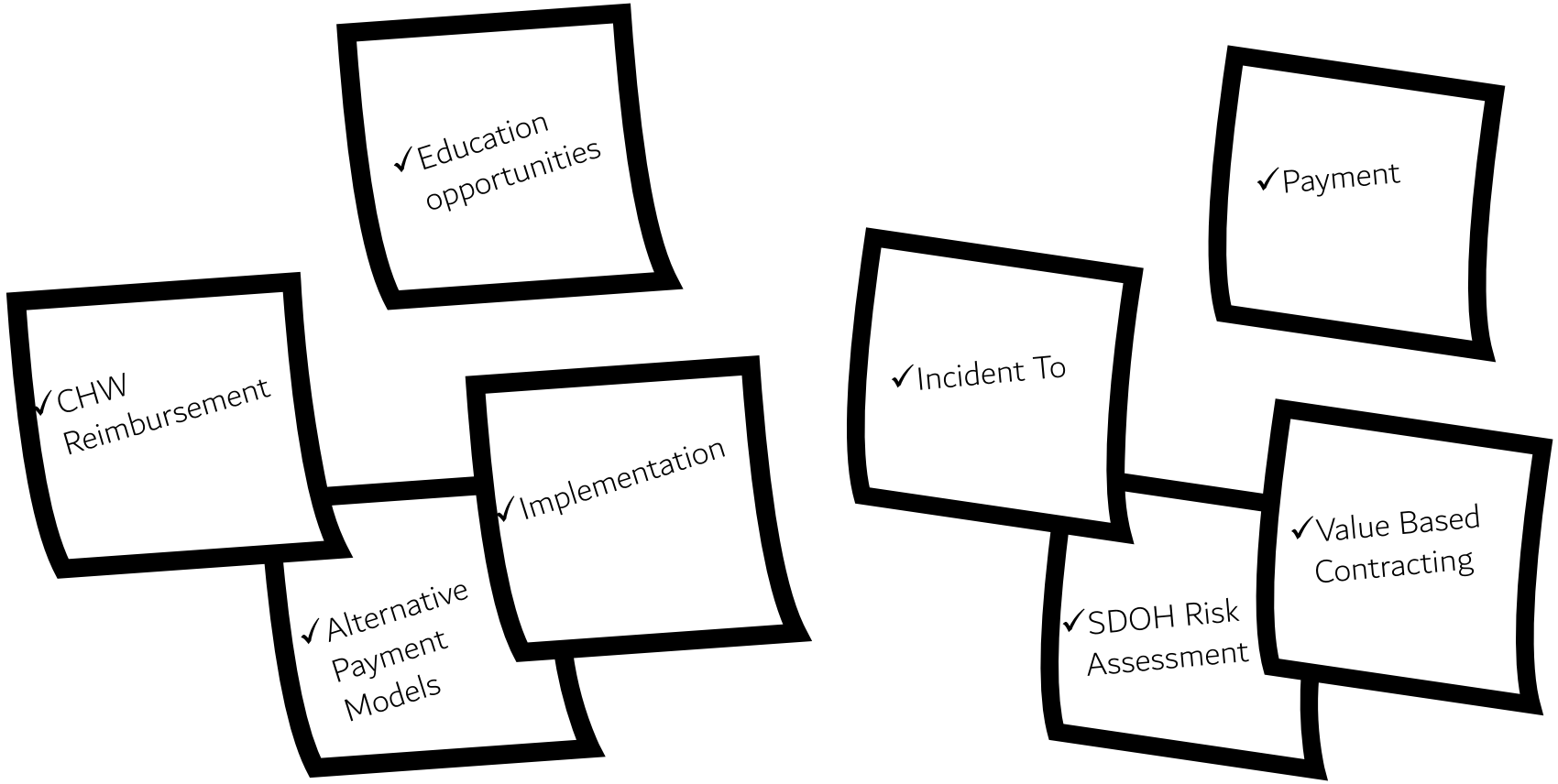
Questions and Discussion



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How to Get Involved in the Partnership…

- Sign up for our email list: https://www.partnership2asc.org/sign-up/

- Follow the Partnership on social media:

www.linkedin.com/company/partnership-to-align-social-care

@partnership2asc

- Reach out directly to:
  - ✓ *Support the Partnership*
  - ✓ *Ask about getting involved in leadership/workgroup activities*
  - ✓ *Share your expertise/experiences*

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