Partnership
to Align Social Care

A National Learning
& Action Network

September 9, 2024

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services (HHS)
Attention: CMS-1807-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via http://www.regulations.gov.

RE: [CMS-1807-P] Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments.

Dear Administrator Brooks-LaSure:

On behalf of the Co-Chairs of the Partnership to Align Social Care (Partnership), which serves as a national learning and action network with the purpose of advancing the alignment between healthcare and social care service delivery systems, and the below signed organizations representing numerous health and social care sector stakeholders, we are writing in response to the CY2025 Medicare Physician Fee Schedule (PFS) [CMS-1807-P].

The Partnership has brought together leaders from across the healthcare and social care sectors, including health plans, health systems, providers, community-based organizations, national associations, and government representatives that share the common goal of supporting efficient and sustainable ecosystems needed to provide individuals with holistic, equitable, community-focused, and person-centered care. Achieving this shared vision includes pursuing opportunities to enhance and sustain contracted partnerships between healthcare entities and social care providers, particularly community-based organizations organized into networks led by Community Care Hubs (CCHs).

We appreciate the opportunity to comment on the extension of telehealth flexibility; changes to caregiver training services; MSSP ACO quality measure for SDOH screening; and the Advanced Primary Care Management Benefit. This comment letter is intended as a stand-alone submission in response to the CY2025 Medicare Physician Fee Schedule (PFS) proposed. Please also see our comment letter in response to the request for information (RFI) for services addressing health-related social needs (HRSNs).

Extension of Telehealth Flexibility

> The current flexibility on the application of telehealth services to include the waiver of geographic and originating site restrictions is set to expire on December 31, 2024. While we understand that CMS does not have the authority to extend the current waiver to allow continued flexibilities of telehealth services beyond the end of this year, we urge the agency to work with Congress to secure a temporary or permanent extension of the current waiver of geographic and originating site restrictions.

The telehealth flexibilities enacted under the Public Health Emergency and additional extensions of the flexibility have expanded access to care for many Medicare beneficiaries. These flexibilities and inclusion of audio-only technology have been especially important in rural settings and medically underserved areas. Ending telehealth flexibilities will have a profound negative impact on these populations. Specifically, organizations have used the telehealth flexibilities to complete the initiating visit for persons that require Community Health Integration (CHI) and Principal Illness Navigation (PIN) services. The CHI/PIN benefits reimburse for services to support transitions of care. Persons that have health-related social needs (HRSNs) have significant challenges with accessing care to obtain an initiating visit, especially when the patient is experiencing transportation insecurity, which is a direct barrier to completing the required initiating visit for CHI/PIN/PIN-PS. We will advocate for Congress to take action to provide a statutory requirement for the current telehealth flexibilities to extend until CY2026 or make the flexibilities permanent. Extending current telehealth flexibility will improve access to care for essential services for populations that are disproportionally impacted by HRSNs.

Caregiver Training Services (CTS) & Direct Caregiver Training Services

In the CY2024 Physician Fee Schedule Final Rule, CMS created a set of HCPCS codes for Caregiver Training Services (CTS). The CTS benefit is part of a broader set of HRSNs services that were created to promote health equity (CTS CPT codes implemented in 2024: 96202, 96203, 97550, 97551, and 97552). In the CY2025 Physician Fee Schedule Proposed Rule, CMS proposes to create a new set of codes to support Direct Caregiver Training Services (DCTS), which would include caregiver training services for clinical skills required to effectuate hands-on treatment needed to reduce complications and monitoring the patient.

We applaud CMS for addressing the need for caregiver training services in the Medicare fee schedule. However, both the original CTS benefit and the proposed Direct CTS are difficult to implement because of structural barriers in the policy, which do not allow for the use of appropriately trained auxiliary personnel to provide CTS under general supervision as an incident to service. The current benefit requires a provider to fit expanded caregiver training services into clinical settings that are established to complete E/M encounters, which requires clinicians to have fixed appointments in small exam rooms. The fixed 15–30-minute E/M encounter in a small exam room are not conducive to the completion of extensive training required of caregivers. In addition, there are multiple evidence-based or evidence-informed caregiver training programs that are funded by the U.S. Administration for Community Living (ACL), which could be leveraged to meet the growing need for caregiver training including:

- Powerful Tools for Caregivers (https://www.powerfultoolsforcaregivers.org)
- Savvy Caregiver® (https://savvycaregiver.com)

There is a national network of organizations that currently provide essential caregiver training services. These critical services are limited in reach and scope primarily because of limited funding. Increasingly, evidence-based caregiver training program providers are partnering with healthcare providers across the country to deliver services and training to ease the burden of caregivers. Currently, caregiver training programs are often provided under general supervision of a qualified healthcare provider but are not reimbursable because of the restriction on billing for CTS using auxiliary personnel as an incident to service provided under general supervision. The adoption of essential caregiver training services would be vastly expanded if CTS were permitted to be provided as an incident to service that can be provided by trained auxiliary personnel operating under general supervision. Allowing CTS to be delivered by auxiliary personnel would also benefit minority and geographically isolated populations. The current standard of practice dictates that caregiver training must incorporate the cultural beliefs and mores of targeted communities.

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Existing interventions have been effectively replicated to reflect cultural diversity of the population served, which is essential to achieving health. Existing culturally relevant caregiver training programs are often delivered through local, trusted, and appropriately trained community-based providers. Allowing CTS and DCTS to be conducted as an incident to service under general supervision would expand access to existing, proven, culturally humble best-practice caregiver training programs.

We urge CMS to change the Caregiver Training Service benefit and the proposed Direct Caregiver Training Services benefit to allow a qualified healthcare provider to bill for all caregiver training services when rendered by trained auxiliary personnel as an incident to benefit, under general supervision.

Medicare Shared Savings Program ACO Quality Measure for Screening for Health-Related Social Needs

We applaud CMS for recognizing the impact of health-related social needs (HRSNs) on health outcomes for the Medicare population through the inclusion of a HRSN screen quality measure for ACOs. There is a growing evidence-based documenting the real impact of HRSNs on health outcomes and total cost of care. To succeed in the Medicare Shared Savings Program ACOs must screen and address HRSNs. While we applaud CMS for including screening for HRSNs in the quality measures, we encourage CMS to consider also including a measure related to addressing identified HRSNs in the quality measures. It is inappropriate to identify HRSNs that impact health outcomes and not deploy community-based interventions to address identified needs. [1] The evidence is overwhelming that screening and addressing HRSNs is an essential element of whole-person care. Therefore, we support adopting an HRSN screening measure, but also urge CMS to consider a measure documenting HRSN intervention deployment.

Further, while we understand and fully appreciate that MSSP ACOs will need appropriate time to incorporate additional quality measures, we encourage CMS to consider a timeline to enact these measures prior to 2028. Specifically, we urge CMS to consider adopting a phased approach to deploying measures, such as making HRSN-related measures optional for an initial period of time and moving to mandatory adoption before 2028.

Advanced Primary Care Management (APCM) Benefit

We applaud CMS for recognizing the essential role of primary care and investing to strengthen primary care through the Advanced Primary Care Management benefit. The structure of the APCM benefit incorporates essential elements of chronic care management and transitional care management, and we agree that providers that bill for APCM should not be reimbursed for Chronic Care Management (CCM) and Transitional Care Management (TCM). We also agree that Community Health Integration (CHI), Principal Illness Navigation (PIN), and Principal Illness Navigation-Peer Support (PIN-PS) are distinctly different and should be separately reimbursed from APCM.

We strongly recommend that CMS approve the APCM benefit without including CHI/PIN/PIN-PS as a bundled service in the APCM benefit. CHI/PIN/PIN-PS are distinctly different from the proposed APCM benefit structure and should be separately reimbursable for providers that are providing APCM.

On behalf of the Partnership to Align Social Care Co-Chairs and the undersigned organizations, we appreciate the opportunity to comment on the RFI regarding implementation of CHI/PIN/PIN-PS services included in the proposed rules for the CY 2025 Physician Fee Schedule.

[1] The Accountable Health Community (AHC) Model, Second Evaluation report documented statistically significant results demonstrating the impact on reducing total cost of care for beneficiaries that received navigation assistance to address identified HRSNs. RTI International. Accountable Health Communities (AHC) Model Evaluation: Second evaluation report. May 2023. Available online.

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Sincerely,

Co-Chairs, Partnership to Align Social Care

Timothy McNeill, RN, MPH
CEO, Freedmen's Health Consulting

June Simmons, MSW
CEO, Partners in Care Foundation

SIGNING ORGANIZATIONS

NATIONAL

A2 Associates, LLC, Jamestown, NY
American Association on Health and Disability, Rockville, MD
Concert Health, San Diego, CA
Eviset, New York, NY
Independent Living Systems, LLC, Doral, FL
Lakeshore Foundation, Birmingham, AL
National Association of Nutrition and Aging Services Programs (NANASP), Washington, DC
National Council on Aging, Arlington, VA
National Partnership for Women and Families
Pathways Community HUB Institute, Toledo, OH
Robinson Ventures, LLC, Hartsville, SC
Stratis Health, Bloomington, MN
The Camden Coalition, Camden, NJ
The Caregiving Years Training Academy, Park Ridge, IL
USAging, Washington, DC
YMCA of the USA, Chicago, IL

STATE

Access Tusc, Bridges to Wellness Pathways HUB, New Philadelphia, OH
AgeOptions, Oak Park, IL
Archstone Foundation, Beach, CA
Bay Aging dba VAAACares, Urbanna, VA
Better Health Partnership, Brooklyn Hgts., OH
CareLink, East Providence, RI
Careway LLC dba 1Heart Caregiver Services – Irvine, Tustin, CA
Community Clinical Advances LLC, Portland, OR
Detroit Area Agency on Aging, Detroit, MI
Great Lakes Physicians Organization, Midland, MI
Healthy Alliance, Schenectady, NY
Iowa Community HUB, West Des Moines, IA
Mass Home Care, Malden, MA
Ohio Association of Area Agencies on Aging, Columbus, OH
Oregon Wellness Network (OWN), Salem, OR
Partners in Care Foundation, San Fernando, CA
Trellis, Arden Hills, MN

LOCAL

101 Ways nfp, Cahokia Heights, IL
AgeSpan, Inc., Lawrence, MA

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Aging and In-Home Services of Northeast Indiana, Inc., Fort Wayne, IN
Beach Cities Health District, Redondo Beach, CA
Care Choice Home Care, Vista, CA
Comfort Keepers, San Diego, CA
Comfort Paradise Home Care Agency, Los Angeles, CA
Community Health Training Institute, DFW, Arlington, TX
Easter Seals North Georgia, Inc, Atlanta, GA
Green Tree Home Care, Santee, CA
Health and Welfare Council of Long Island, Huntington Station, NY
Matrix Care Services, LLC, Encino, CA
MettaHealth Partners, Chicago, IL
Northern Michigan Health Consortium, Charlevoix, MI
Rose's Agency Home Care, Los Angeles, CA
Senior Home Advocates, Irvine, CA
Spectrum Generations d/b/a Healthy Living for ME, Augusta, ME
St Louis CHW Coalition, St Louis, MO
The Network of Behavioral Health Providers, Houston, TX
Western New York Integrated Care Collaborative, Buffalo, NY
YMCA of Metropolitan Milwaukee, Milwaukee, WI

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