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 Proposed Rule [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 **Request for Information** (RFI) for Services Addressing Health-Related Social Needs (HRSNs) Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136): Community Health Integration, Principal Illness Navigation, Principal Illness Navigation-Peer Support

Recommendations for Services that are not currently covered under the current HCPCS Coding

We recommend that CMS consider the use of additional flexibilities in the coding for addressing HRSNs to include the ability to pay for a set of targeted HRSN interventions to address food insecurity and target nutrition as detriment of health. A time-limited food intervention has been demonstrated to have profound impacts on persons with food insecurity. The Accountable Health Community (AHC) model screened over one million beneficiaries for Health-Related Social Needs (HRSN). The AHC Second Evaluation report detailed that food

insecurity was the most prominent HRSN for the population.[1] "Food insecurity (63 percent) and housing instability (47 percent) were the most common needs reported by screened beneficiaries with at least one HRSN."

There has also been significant adoption of home-delivered meals and medically tailored meal benefits for Medicaid beneficiaries which is directly attributed to additional flexibilities provided by the Center for Medicaid and CHIP Services. In fact, almost all 1915 Waivers for persons that require assistance with one or more activities of daily living (ADLs) include a home-delivered meal benefit. Although the impact of a direct meal benefit is long standing in the Medicaid program, beneficiaries eligible for Original Medicare that do not qualify for Medicaid do not have a direct benefit to address inadequate nutrition or food insecurity HRSNs. The time sensitive nature of ensuring adequate access to food, particularly in the post-acute period necessitates the creation of a direct benefit to address this HRSN. The ability to directly address food insecurity can have a profound impact on populations with nutrition-sensitive conditions and persons during transitions of care. We urge CMS to consider exploring the use of additional coding flexibility to address this HRSN. The additional coding would support the development of a payment pathway for the provision of a limited-term nutrition-focused intervention to include the following:

- Home-Delivered Meals
- Medically Tailored Meals
- Medically Tailored Groceries
- Produce Prescriptions

The provision of direct interventions to address food insecurity is particularly important when a person is transitioning from a hospital or SNF to a community setting. Persons recently discharged from an institutional setting with food insecurity will have profound limitations in managing their health condition(s) that caused the admission without access to the appropriate diet. While ongoing efforts, such as the Gravity Project's Coding4Food initiative, are focused on developing adequate codes to document and bill for nutrition-related interventions, the current HCPCS billing code set does not provide the ability to directly address the HRSN in the immediate post-discharge period that would contribute to readmissions.[2]

CHI/PIN codes provide reimbursement for the labor required to address HRSNs, but this labor will have minor impact on addressing immediate needs to address food insecurity post discharge. The cost effectiveness of providing medically tailored meals, during transitions of care, has been well documented. According to a recent JAMA article that analyzed the cost effectiveness of Medically Tailored Meal interventions found the following, "This economic evaluation among 6,309,998 eligible US adults found that national implementation of MTMs for patients with diet-sensitive conditions and activity limitations could potentially be associated with 1.6 million averted hospitalizations and net cost savings of $13.6 billion annually from an insurer perspective."[3] Furthermore, a recent JAMA article that evaluated the association of a 4-week post-hospitalization home-delivered meals benefit with 30-day all-cause rehospitalization and mortality indicated that the "home-delivered meals benefit was associated with lower odds of 30-day rehospitalization and death."[4]

The impact of providing home-delivered and medically tailored meals to this population is consistently present in Medicaid 1115 waiver, 1915 waiver, and In Lieu of Service (ILOS) applications because of the demonstrated

[1] RTI International. Accountable Health Communities (AHC) Model Evaluation: Second evaluation report. May 2023. Available online.
[2] Gravity Project's Coding4Food confluence page: https://confluence.hl7.org/pages/viewpage.action?pageId=184932452; Coding4Food website https://www.msfnca.org/coding4food
[3] Hager, K. 2022. *JAMA Netw Open*. 2022;5(10): e2236898. doi:10.1001/jamanetworkopen.2022.36898. Available Online: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797397).
[4] Hager K, Cudhea FP, Wong JB, et al. Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US. JAMA Netw Open. 2022;5(10):e2236898. doi:10.1001/jamanetworkopen.2022.36898

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cost effectiveness of the intervention. We urge CMS to use the precedents in the Medicaid program and cost effectiveness research to establish a payment pathway to address patient nutrition needs through the provision of a direct, time-limited benefit that includes a) Home-Delivered Meals, b) Medically Tailored Meals, c) Medically Tailored Groceries, and d) Produce Prescriptions.

Recommendations to address current barriers to CHI/PIN/PIN-PS adoption

1. ***Time-based billing:***

The current minimum billing threshold for CHI/PIN/PIN-PS is 60 minutes per calendar month. The 60-minute minimum threshold is a barrier to adoption and implementation. When CHI/PIN/PIN-PS services are performed on behalf of a beneficiary and the time per calendar month is below the minimum 60-minute threshold, the organization cannot receive reimbursement for the work performed. It is well documented that persons with multiple HRSNs will require assistance over an extended period to resolve their HRSNs.[5] While the duration of the interventions may extend over time, the intensity of the labor, each calendar month, will vary. The HCPCS billing codes should accommodate months where the time required will be less than the minimum threshold of 60 minutes. The data from the accountable health community, second evaluation report, validates the contention that interventions to address HRSNs will occur over an extended period to meet all identified needs. Most beneficiaries in the AHC model did not have all their HRSNs resolved after a year of receiving navigation services.

"Among those with more than one HRSN, 38 percent had at least one HRSN resolved, and 20 percent had all their needs resolved. An additional 11 percent of beneficiaries were connected with a community service provider (CSP) for at least one HRSN but had not had any of their HRSNs resolved."[6]

Given the fact that Medicare beneficiaries may not have all of their HRSNs resolved, after a year of receiving CHI/PIN/PIN-PS services, it is unlikely that the labor time requirements during the first month will be equal to the labor time requirements over the course of time working with the beneficiary. As a result, there may be waning time requirements to address HRSNs over the course of time that the person receives CHI/PIN/PIN-PS services. There is the potential that after the initiating month for CHI/PIN/PIN-PS, the subsequent months may require less labor to address the identified HRSNs than the minimum 60-minute threshold. The 60-minute threshold creates the potential that CHI/PIN/PIN-PS labor under the 60-minute threshold will be uncompensated. Therefore, we believe that there should be an option for reimbursement to occur when the interventions deployed to address HRSNs fall below the 60-minute threshold.

We urge CMS to consider lowering the 60-minute minimum threshold to bill CHI/PIN/PIN-PS labor to 20 minutes per calendar month, with an additional HCPCS code unit for each additional 20 minutes, up until the first hour. After the first hour, then there would be a HCPCS code for each additional 30 minutes. There is precedence for using a time-based allocation which has a minimum base of 20 minutes, with additional HCPCS codes for each additional 20 minutes for the first hour. The current billing structure for Chronic Care Management (CCM) has a similar time allocation process:

99490 – First 20 minutes of chronic care management services, per calendar month
99439 – each additional 20 minutes, after the first 20 minutes, per calendar month

[5] *Supra* at 1
[6] *Supra* at 1

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The chronic care management Medicare Learning Network guide provides additional explanation on the time-based allocation for chronic care management:[7]

Code	Descriptor
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; **first 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; **each additional 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).

2. Initiating Visit during transitions of care:

As currently structured, requiring the initiating visit prior to the start of CHI/PIN/PIN-PS is a barrier to implementation when serving beneficiaries that are admitted to an acute care hospital or emergency department. CHI/PIN/PIN-PS each provide reimbursement for services that are essential when supporting transitions of care among settings. Hospitals are required to screen for HRSNs, under the CY2023 Inpatient Prospective Payment System (IPPS) rule. The CMS IPPS rule has significantly increased the volume of HRSN screening performed by hospitals. As hospitals expand screening for HRSNs, beneficiaries are increasingly identified that require support to transition to, or back to, a community setting.

However, when critical CHI/PIN/PIN-PS are provided prior to the currently accepted initiating visit, those services are uncompensated. To address this barrier to implementation, we request that CMS consider an alternative approach for persons that receive CHI/PIN/PIN-PS services as part of care transitions but prior to the receipt of an initiating visit. We urge the agency to consider retroactively including CHI/PIN/PIN-PS services rendered during transitions of care but prior to the initiating visit as part of the monthly time allocation for billing provided that the subsequent initiating visit occurs within one month of the hospital or acute care setting discharge date. Allowing for retroactive aggregation of time to the discharge date will incentivize the immediate deployment of CHI/PIN/PIN-PS interventions to address identified needs while still adhering to an initiating visit requirement.

Telehealth is an additional solution to conducting the initiating visit during transitions of care. Patients in the immediate post-acute period may have difficulty traveling for an in-person initiating visit. The telehealth service list specifically includes transitional care management because of the recognition of the need to facilitate post-discharge visits as an allowable service via telehealth. Telehealth flexibilities allowed providers to conduct the initiating visit using telehealth in the immediate post-discharge period. Rapidly conducting a transitional care management visit for persons that require CHI and PIN

[7] CMS Medicare Learning Network MLN909188, dated May 2024. Available online: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf)

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allows for interventions to address HRSNs or health navigation needs to be addressed, as part of a whole-person care model that reduces unnecessary readmissions.

Terminating telehealth flexibilities on December 31, 2024, will significantly impede the ability of organizations to conduct CHI/PIN initiating visits. Organizations have demonstrated success with implementing the CHI/PIN initiating visit through the deployment of a community health worker, or other auxiliary personnel, to the home of a beneficiary post-discharge. During this visit a CHW can facilitate the transitional care management/initiating visit via telehealth while deployed at the home and subsequently address immediate issues identified in the home setting that would lead to negative health outcomes such as addressing fall risk and other hazards in the home. We urge CMS to enact an extension or permanent rule change to allow telehealth services to be used as the initiating visit with the inclusion of the waiver of the geographic restrictions, to include the beneficiary home in the immediate post-discharge period.

We urge CMS to allow CHI/PIN/PIN-PS services to be provided retroactive to the discharge date provided the beneficiary has an initiating visit within 30-days of discharge. In addition, we urge CMS to work with Congress to achieve a temporary extension or permanent solution to the planned termination of telehealth flexibilities that is scheduled to occur on December 31, 2024. We request a waiver on the planned termination to allow telehealth visits to occur without geographic restriction during the immediate post-discharge period to conduct a transitional care management visit to serve as the initiating visit for CHI/PIN services.

3. ***Initiating Visit for persons seen in the emergency department for a substance use disorder (SUD):***

The national opioid crisis has caused a profound increase in fatal and non-fatal overdoses arriving in local emergency departments (EDs). The recent CMS rule reducing restrictions on prescribing buprenorphine has empowered emergency departments to implement protocols to initiate buprenorphine treatment in the ED. When a person with an Opioid Use Disorder (OUD), receives an initiating dose of buprenorphine in the ED, they must receive follow-up treatment with a community provider. Unfortunately, many people that receive their buprenorphine in the ED fail to follow up with a community provider for ongoing buprenorphine administration. To provide additional support and ensure required follow up with a community provider for buprenorphine administration, EDs often hire peer support/recovery workers to provide peer support services beginning in the emergency department and then following the patient's return to the community. It is essential to initiate peer support services at the onset of buprenorphine administration when a person has a non-fatal overdose. Unfortunately, the initiating visit requirement directly impedes the ability to deploy peer support services to persons when it is most needed—after a non-fatal overdose with buprenorphine administration in the emergency department.

We urge CMS to provide additional flexibility for beneficiaries that receive PIN-PS to address an SUD during an emergency room encounter. The PIN-PS should be reimbursable retroactive to the ED encounter provided the beneficiary has an initiating visit within 30 days of discharge from the emergency department.

4. ***Barriers for geographically isolated communities (e.g., Rural, Tribal, and Island Communities):***

The initiating visit is a significant barrier to implementation for geographically isolated communities. Persons that are negatively impacted by HRSNs or have a serious high-risk condition that requires PIN have the increased burden of completing an initiating visit prior to the receipt of CHI/PIN/PIN-PS

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services. This is particularly challenging when a person lives in a geographically isolated community and has transportation insecurity, which requires the beneficiary to overcome their transportation insecurity so that they can get assistance with transportation insecurity.

To address the barriers to travel for an initiating visit in geographically isolated communities, providers can currently leverage telehealth to conduct the initiating visit. Telehealth is a vital tool to address the need for the initiating visit for geographically isolated communities. Using this approach, the clinician can deploy a community health worker or other auxiliary personnel to the home of the beneficiary to support the implementation of a telehealth visit with the provider. The community health worker deployed to the home of the beneficiary can initiate the telehealth visit with the provider which can be counted as the initiating visit for CHI/PIN/PIN-PS. During the telehealth encounter, the provider can establish the medical necessity of CHI/PIN/PIN-PS, and then the community health worker can deploy interventions to address identified needs.

Unfortunately, the flexibilities allowing telehealth in the home of a beneficiary are set to expire on December 31, 2024. The planned termination of the telehealth flexibility, on December 31, 2024, ends a key solution to addressing the initiating visit requirement for geographically isolated communities. We urge CMS to make current telehealth flexibilities permanent to allow telehealth services in the home of a beneficiary, which would allow providers to deploy community health workers and other auxiliary personnel to beneficiary's homes to facilitate the initiating visit by telehealth. Continued flexibility for telehealth is essential to reducing the barriers to CHI/PIN/PIN-PS adoption for geographically isolated communities.

5. ***CHI/PIN/PIN-PS are authorized only when billed by the same provider that conducted the initiating visit:***

The requirement for the provider conducting the initiating visit to be the same provider to bill for the ongoing CHI/PIN/PIN-PS presents a barrier to implementing CHI/PIN/PIN-PS for group practices that use non-physician providers (NPPs) and physicians to manage a population of patients under the medical home model. Under a medical home model, a group practice may have encounters that are billed as an "incident to" visit that is conducted by the NPP.

There are concerns when an initiating visit is conducted by the NPP under "incident to" requirements, that the subsequent billing for CHI/PIN/PIN-PS under the National Provider Identifier Standard (NPI) of the physician is contrary to the intent of the regulations. In this instance there is a concern that the ongoing billing under the physician would be improper because the NPP conducted the initiating visit under the "incident to" requirements.

To avoid this potential conflict, we urge CMS to require the initiating visit at the group practice level, instead of the individual provider level. This would allow for any provider in the group to conduct the initiating visit and then to bill for ongoing CHI/PIN/PIN-PS services in subsequent months. A rule change that would support initiating visits at the group practice NPI level would be aligned with the medical home model under which most group practices operate.

We urge CMS to allow CHI/PIN/PIN-PS to be billed by any provider in a group practice, when an eligible provider in the group practice that conducted the initiating visit.

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6. ***Scope of Practice barriers to implementation of CHI:***

Currently, CMS authorizes clinical social workers (CSWs) to conduct the social determinants of health (SDOH) risk assessment. When the CSW completes the SDOH risk assessment HRSNs are identified and documented. The SDOH risk assessment is an add-on service with HBAI or a psychotherapy service. When the CSW identifies HRSNs, during the SDOH risk assessment, the CSW is not authorized to deploy CHI services to address identified needs.

The limitation of CSWs to directly provide and bill for CHI disrupts the continuum of care by preventing CSWs from deploying interventions to address identified needs as the supervising clinician. Unfortunately, the CSW must refer the beneficiary to a physician/NPP to conduct a separate initiating visit and screen for HRSNs, after the CSW already identified the HRSNs impacting the beneficiary. The requirement of the CSW to identify HRSNs, through the SDOH Risk Assessment benefit but inability to address the identified HRSNs through the delivery of CHI services, creates a significant barrier to CHI access.

The scope of practice of CSWs includes supervising of auxiliary personnel to address HRSNs. We urge CMS to allow CSWs to conduct the CHI initiating visit and supervise CHI services as an eligible CHI provider. The current rule allows CSWs to conduct the SDOH risk assessment to identify HRSNs but does not allow CSWs to supervise the deployment of CHI services to address identified needs, which disrupts the continuum of care and reduces access to CHI services.

We urge CMS to change this policy to allow CSWs to conduct initiating visits for CHI when they conduct an HBAI, or psychotherapy visit and provide supervision of auxiliary personnel providing CHI to address identified needs. This will increase access to CHI services for vulnerable populations. Authorizing CSWs to conduct the initiating visit would mitigate the barrier to implementation when a CSW identifies HRSNs during an SDOH risk assessment.

We urge CMS to expand the authority of Clinical Social Workers to include completing the initiating visit for CHI and subsequent supervision of auxiliary personnel to bill for CHI – with the CSW operating as the rendering provider.

7. ***Barriers to Community Care Hub adoption of CHI/PIN:***

The HHS Call to Action for Addressing Health Related Social Needs highlights the promising practice of Community Care Hubs (CCH).[8] "Hubs leverage community capacity and expertise to allow for an efficient, scalable approach to health care/CBO partnerships that can facilitate care coordination and service delivery to address HRSNs." Based on the HHS call to action there has been considerable growth and adoption of the CCH model.

When a CCH deploys in a defined market, the CCH becomes the central resource to deploy auxiliary personnel to address HRSNs for hospitals and providers in their region. The initiating visit requirement creates a barrier to deployment of the CCH model to implement CHI/PIN/PIN-PS services when CCHs partner with multiple providers in a defined market. The initiating visit rule applied to a CCH in a defined market requires the CCH to secure contracts with every small and large practice in the region. The increased cost and complexity of managing multiple contracts with providers across a defined region impedes the adoption of CCHs to implement CHI/PIN/PIN-PS.

[8] Available Online: https://aspe.hhs.gov/sites/default/files/documents/3e2f6140d0087435cc6832bf8cf32618/hhs-call-to-action-health-related-social-needs.pdf

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Some CCHs are overcoming the barrier of contracting with multiple providers across a defined market by hiring a physician or NPP and creating a group practice to bill for the initiating visit and subsequent CHI/PIN/PIN-PS. This model includes having the CCH directly employ or contract with a physician or NPP to work within the CCH to conduct the initiating visit under the EIN of the CCH.

This approach requires the CCH to create a legal entity that is eligible to enroll in Medicare as a group practice. While some CCHs have implemented a group practice model, it is implausible to expect that all CCHs develop internal capacity to establish a group practice to complete the initiating visit and supervise CHI/PIN/PIN-PS. Additional flexibilities regarding the initiating visit would support the adoption and deployment of CCHs as a federally recognized and recommended method to scale models that effectively and efficiently address HRSNs in a defined community.

Therefore, we urge CMS to consider additional flexibilities for the initiating visit requirement to support the adoption and implementation of the community care hub model to ensure that regional hubs can deploy HRSN interventions, which will serve as a resource available to multiple hospitals and physicians in a defined market.

8. ***Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) barriers to adoption of CHI/PIN/PIN-PS:***

Currently, FQHCs and RHCs use one HCPCS code (G0511) to bill for CHI/PIN/PIN-PS. The use of G0511 as the only code approved for use by FQHCs/RHCs for a range of services has been a significant barrier to implementing CHI/PIN/PIN-PS within these entities. The requirement that only one provider bill for CHI/PIN/PIN-PS at a time, while simultaneously requiring FQHCs/RHCs to bill for a range of care management services under the same code, places FQHCs/RHCs at considerable risk of having denied claims for duplicate services. The risk of a claim denial because another provider is rendering a different service coded under the same HCPCS code (G0511) is a barrier to implementation. Because FQHCs/RCHs cannot delineate which care management service is being rendered, providers are less likely to provide CHI/PIN/PIN-PS services due to concern that claims will be denied.

A second barrier to FQHC/RHC adoption of CHI/PIN/PIN-PS is a lack of clarity regarding the volume of CHI/PIN/PIN-PS that can be provided to a beneficiary during a calendar month. FQHCs/RHCs operate in medically underserved areas and serve populations that are primarily low income. Consequently, many FQHCs and RHCs have a patient pool that is disproportionately impacted by unmet HRSNs. FQHCs/RHCs are the backbone of the healthcare safety net in the United States and must have the capacity of FQHCs/RHCs to address the HRSNs impacting the populations they serve. Limiting FQHC/RHC billing of CHI/PIN/PIN-PS is counterproductive to meeting the needs of the populations they serve.

We strongly urge CMS to implement a policy to allow FQHCs/RHCs to bill for CHI/PIN/PIN-PS, using the same set of HCPCS billing codes available to traditional providers. In addition, FQHCs/RHCs should be afforded the opportunity to bill for CHI/PIN/PIN-PS with no cap or limit on the volume of services rendered to a beneficiary per calendar month.

9. ***Strategies that CMS can implement to increase provider adoption of CHI/PIN/PIN-PS:***

We encourage CMS to provide guidance, technical assistance, and resources to incentivize adoption of CHI/PIN/PIN-PS. CMS-branded implementation support materials would increase awareness of and

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interest in provider implementation of critical services to address HRSNs. For example, when CMS approved the CCM benefit, the agency also launched an outreach and education campaign to ensure that providers and beneficiaries were aware of the benefit. Additionally, CMS created a website Connected Care, featuring a series of CCM implementation support materials.

Creating agency branded materials about CHI/PIN/PIN-PS codes that target providers and beneficiaries will increase adoption of this essential benefit. The CMS Connected Care website establishes a precedence for the deployment of targeted CMS-branded resources to support provider adoption of CHI/PIN/PIN-PS services.

We urge CMS to use the precedence set through the creation of the Connected Care website, for chronic care management services, to create a range of provider and beneficiary resources specifically to support adoption of the CHI/PIN/PIN-PS services.

10. Group-based interventions for Principal Illness Navigation

The Principal Illness Navigation benefit should include an option for group-based interventions, which are not currently allowed under the HCPCS PIN codes. Principal Illness Navigation (PIN) is a benefit that provides health navigation, health education, and other supports for persons with serious, high-risk conditions that are expected to last at-least three months and without intervention could lead to further deterioration. Research demonstrates that patients with chronic conditions can improve their health outcomes through the application of improved disease self-management skills. The Centers for Disease Control and Prevention (CDC) has a website that provides information and links to evidence-based training programs that are appropriate for persons managing chronic conditions.[9] The CDC Living with a Chronic Condition webpage recommends persons with chronic conditions learn more about their conditions and how to manage these conditions.

The list of evidence-based Chronic Disease Self-Management Education Programs are primarily group-based interventions. The absence of a PIN group benefit prevents persons with chronic conditions from participating in CDC-recommended evidence-based disease self-management education programs.

The PIN benefit should include a group intervention to allow persons with serious high-risk conditions to participate in evidence-based chronic disease self-management education programs, and we urge CMS to establish HCPCS codes for group interventions under the PIN benefit to allow persons to participate in evidence-based chronic disease self-management education programs.

11. Group-Based interventions for Community Health Integration

Persons that are negatively impacted by HRSN often require support for enacting behavior change. The current CHI benefit recognizes the need for addressing behavior change through the inclusion of the following services in the allowable intervention categories for CHI:

- Facilitating behavior change
- Building patient self-advocacy skills
- Facilitating and providing social and emotional support
- Leveraging lived experience when applicable

[9] CDC, 2024. Available Online: https://www.cdc.gov/chronic-disease/living-with/index.html and https://www.ncoa.org/article/evidence-based-chronic-disease-self-management-education-programs/

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There are numerous CMS benefits that allow for group interventions to support necessary behavior change. The evidence is overwhelming that persons obtain tremendous benefit from participating in facilitated group-based interventions aimed at achieving behavior change. The benefits that currently support group-based benefits to support behavior change include the following:

- Medicare Diabetes Prevention Program (MDPP)
- Diabetes Self-Management Training (DSMT)
- Medical Nutrition Therapy (MNT)
- Health Behavior Assessment and Intervention (HBAI)

Group interventions, facilitated by trained auxiliary personnel, provide the appropriate model to solicit and maintain the required behavior change elements in the CHI benefit. However, the current CHI benefit does not include a provision to allow for group-based interventions. The CHI benefit should be modified to include a group HCPCS code to allow for CHI interventions to be provided in a group-based intervention provided the goals of the group intervention align with the objectives in the person-centered CHI plan of care.

We urge CMS to create a HCPCS code for group-based CHI interventions that align with the person-centered plan of care for individuals that require the services to address identified HRSNs.

12. Training requirements for CHI/PIN

Auxiliary personnel that provide CHI/PIN services operate under general supervision of a qualified healthcare provider. The auxiliary personnel must operate within their defined scope of practice, per State requirements for licensure or certification. Absent State requirements for licensure or certification, auxiliary personnel must be trained or certified in the following competencies:[10]

- 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
- Development of an appropriate knowledge base, including of local community resources

The current training requirements include all the elements for a Bachelor and Master of Social Work degree, however personnel that have completed all the degree requirements for a BSW or MSW are finding that they are being asked to pursue additional training to meet the minimum training requirements to provide CHI/PIN. When a person has applicable education that meets the training requirements, we believe that proof of degree completion along with a transcript that shows satisfactory course completion and the names of the courses, should meet the training requirement for CHI/PIN. The current training requirements do not explicitly state that applicable college training, to include BSW and MSW courses that provide equivalent course instruction would meet the CHI/PIN requirements for non-licensed personnel to operate under general supervision if they met the State requirements for licensure or certification.

[10] CMS. 2024. Health-Related Social Needs FAQ. Available Online: https://www.cms.gov/files/document/health-related-social-needs-faq.pdf

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We urge CMS to amend the training requirements to clearly state that applicable college degree course completion, including BSW and MSW degree courses, meet the training requirement for auxiliary personnel providing CHI/PIN if the person complies with current State requirements for licensure or certification and provide a transcript showing proof of educational attainment.

13. Clarification of person-centered assessment and facilitating patient-driven goal setting for CHI/PIN

The current CHI and PIN benefits both have a provision for person-centered assessment and facilitating patient-driven goal setting. There has been confusion regarding the application of these services and the implementation of the SDOH Risk Assessment benefit. The lack of clarity about the way that these services are complementary in nature, results in organizations not counting time towards the deployment of person-centered assessment and facilitating patient-driven goal setting out of fear of duplication of services.

The Accountable Health Communities (AHC) model documented the impact of screening for HRSNs in clinical settings. One of the documented findings was that persons that were impacted by interpersonal violence did not routinely report this finding when screened in clinical settings. However, the same beneficiary would report interpersonal violence when they completed a person-centered assessment performed in a trusted community setting. Therefore, the person-centered assessment, performed in addition to a SDOH Risk Assessment, is vital to completing a whole-person model of care. Additional clarification is required to prevent providers from excluding time performing the person-centered assessment and facilitating patient-driven goal setting as a separate and distinct service from the SDOH Risk Assessment, not a duplication of services.

We urge CMS to clearly state that the person-centered assessment and facilitating patient-driven goal setting are separate and distinct benefits that would not be considered as duplicate services when performed by auxiliary personnel operating under general supervision of the qualified healthcare provider.

14. Barriers to CHI/PIN to support care of beneficiaries with a fracture:

Beneficiaries that have a fracture resulting from a fall are usually admitted to a hospital and have a surgical repair by an orthopedic surgeon. The beneficiary may transfer to a skilled nursing facility (SNF) and then back to the community. The episode of care requires close coordination through each transition. In addition, follow up after the return to the community should include management of underlying osteoporosis that is often present and a contributing factor to the fracture. The ongoing management of the underlying osteoporosis will not be performed by the orthopedic surgeon that repaired the fracture, however currently opportunities to deploy CHI/PIN services to support the coordination of care from hospital admission to SNF and follow-up management in the community are limited because of the initiating visit requirement. CHI/PIN services could serve to support the implementation of a central coordinating process to support implementation of evidence-based fracture care for persons with osteoporosis. Unfortunately, care coordination required for beneficiaries that require surgical repair of fractures during the acute admission and transfer to SNF does not allow the initiating visit needed to approve CHI/PIN services that would support the transitions of care from hospital to SNF to community.

In addition, persons that endure a fracture-related episode of care are more likely to experience transportation insecurity and food insecurity upon return to the community, which will further impede

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adherence to evidence-based models of care. Furthermore, bundling fracture care as part of a global payment will not support increased coordination required through multiple transitions before arriving in the community. This is particularly important when HRSNs will impact the health outcome of the post-surgical follow-up.

Therefore, we urge CMS to provide flexibility in the initiating visit requirement for patients that transfer from hospital to SNF to community to accommodate improved coordination of care transitions for populations that require expanded care coordination for the duration of the episode of care. This additional flexibility should allow for separate billing for CHI/PIN during the episode of care for fracture care. In addition, the CHI/PIN services provided during a fracture episode of care should begin on discharge from an acute care admission and support the transition to SNF and then to community with retroactive billing for CHI/PIN back to the date of hospital discharge.

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.

Sincerely,

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