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August/September XX, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS-1784-P)

To Whom It May Concern:

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The number of health center Medicare patients has increased significantly over the past 10 years, increasing from 1.5 million in 2010 to 3.3 million in 2022, currently making up 11% of patients health centers serve. The health center model of care provides Medicare patients affordable and high-quality care. Health centers play an integral role in helping lower out of pocket costs for Medicare patients from spending more money; areas with high health center penetration have 10% (\$926) lower Medicare spending per beneficiary. This can be attributed to the COVID-19 PHE flexibilities, which has allowed health centers to offer a broader range of services to their Medicare patients.

[ORGANIZATION NAME] supports CMS' proposals to expand coverage and billing of Medicare services to better serve our patients. We appreciate CMS efforts to expand access to care with a health equity lens. **[ORGANIZATION NAME]** urges CMS to take an intentional approach to proactively include FQHCs as they develop innovative solutions to address ongoing challenges for safety-net providers and underserved patients.

[ORGANIZATION NAME] welcomes the opportunity to provide comments on the proposed NPRM. In brief, we appreciate CMS considering the following proposals below:

- **[ORGANIZATION NAME]** supports CMS' regulatory change to harmonize in-person requirements for mental health telehealth visits with the Consolidated Appropriations Act of 2023.
- **[ORGANIZATION NAME]** strongly urges CMS to revise the FQHC medical visit definition before the end of the PHE to avoid significant gaps in care for some of the most vulnerable Medicare patients.
- **[ORGANIZATION NAME]** supports CMS amending FQHC regulations to include Licensed Mental Health Counselors (LMHCs) and Licensed Marriage and Family Therapists (LMFTs) to generate a billable visit in Medicare and add them to the list of core Medicare providers.
- **[ORGANIZATION NAME]** supports CMS' proposed changes to a general level of supervision for behavioral health services provided "incident to" physician or NP's services.
- **[ORGANIZATION NAME]** strongly supports CMS' proposal to allow FQHCs to bill for Remote Patient Monitoring/Remote Therapeutic Monitoring (RPM/RTM), Community Health Integration (CHI) services, and Principal Illness Navigation (PIN).

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- **[ORGANIZATION NAME]** appreciates CMS' proposed change to calculating HCPCS code G0511 to ensure more adequate payment for general care management, and recommends including GBHI and CPM in the weighted calculation.
- **[ORGANIZATION NAME]** supports CMS' proposal to increase how providers can obtain patient consent for chronic care management (CCM) services.
- **[ORGANIZATION NAME]** supports allowing MDPP suppliers to continue offering MDPP services virtually using distance learning delivery through December 31, 2027, if they maintain an in-person CDC organization code.
- **[ORGANIZATION NAME]** supports CMS' proposal to reimburse for the screening of social drivers of health (SDOH) through the creation of a standalone G code but urges the agency to clarify language to ensure FQHCs can benefit from this proposal.
- **[ORGANIZATION NAME]** supports CMS' proposal to reimburse for an SDOH Risk Assessment as part of the AWV but asks CMS to clarify language to ensure FQHCs can bill for this optional, additional service.
- **[ORGANIZATION NAME]** applauds CMS' proposal to expand payment under Medicare Parts A and B for certain dental and oral health services in relation to Medicare-covered treatments for head and neck cancer. We urge that the list of billable visit codes modified in this proposed rule be included in the dental bundle for FQHCs.
- **[ORGANIZATION NAME]** recommends CMS adopt a policy that permits providers collect patient consent for CHI service on an annual basis.
- **[ORGANIZATION NAME]** supports CMS' idea to allow interprofessional consultation to enhance BHI and recommends adding the CPT codes to an FQHC qualifying visit and the specific providers to the core providers list.
- **[ORGANIZATION NAME]** supports a broad definition of a nurse practitioner (NP) at § 491.2(1) certification requirements to allow health centers to employ NPs who can best serve their patient population.

Telehealth Mental Health Visits

[ORGANIZATION NAME] supports CMS' regulatory change to harmonize in-person requirements for mental health telehealth visits with the Consolidated Appropriations Act of 2023 (CAA 2023).

[ORGANIZATION NAME] supports CMS' proposed revision to delay the in-person requirements for telehealth mental health visits furnished by FQHCs under Medicare until January 1, 2025, conforming with the passage of CAA 2023. Health centers serve patients who may face substantial barriers to meeting the in-person requirement for mental health visits. Health center patients often lack access to reliable transportation, are older adults with mobility issues, have a disability, or experience homelessness. These are some examples of obstacles patients may have in meeting the in-person requirement and **[ORGANIZATION NAME]** appreciates the continued delay of this requirement. This delay is especially important given the workforce shortages health centers face. In 2021, health centers employed 17,415 full-time behavioral health staff, with psychiatrists and licensed clinical psychologists making up 10% of that workforce at 5% each.¹

[ORGANIZATION NAME] strongly urges CMS to revise the FQHC medical visit definition before the end of the PHE to avoid significant gaps in care for some of the most vulnerable Medicare patients. The same patients who benefit from mental health services through remote

¹ <https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf>

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access deserve that same access to medical services. We urge CMS to consider the consequences if Medicare patients cannot receive virtual FQHC medical services due to a lapse in coverage and reimbursement. Beginning January 1, 2025, Medicare patients who *choose* to utilize FQHC services will not have access to the same virtual services that other Medicare beneficiaries enjoy due to this lack of regulatory flexibility. Health centers cannot continue to carry out their critical role as primary care safety-net providers unless Medicare recognizes patients receiving health center services through remote access.

In the past, CMS has stated it lacks statutory discretion to amend the “visit” definition in this manner because FQHCs are not included as “distant site providers” for the purposes of telehealth services in Section 1834(m). However, CMS previously acknowledged in the preamble to its PFS CY 22 rulemaking that it does have the authority to amend the “visit” definition. **[ORGANIZATION NAME]** encourages CMS to use its authority vested by Congress to broaden the FQHC visit definition to include virtual capabilities for medical visits.

[ORGANIZATION NAME] believes CMS has the regulatory authority to revise the regulation at § 405.2463, paragraph (b)(1) to define a medical visit as a face-to-face encounter or encounter where services are furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where beneficiaries are not capable of or do not consent to, the use of devices that permit a two-way audio/video interaction for the purposes of diagnosis, evaluation or treatment of services under (b)(2). Additionally, CMS should amend cost reporting instructions to ensure the costs associated with services under (b)(2) and (b)(3) are included as “FQHC services” on the cost report.

Telehealth has been crucial in bridging gaps in care for health center patients. In 2021, 99% of health centers nationwide offered telehealth services compared to just 43% in 2019. Fifty-eight percent of telehealth visits were for mental health, 33% for behavioral health services, 7% for enabling services, and 2% for other services.² Overall, health care providers saw increased utilization of mental health services over the course of the pandemic – the percentage of adults who sought out mental health treatment increased from 19.2% in 2019 to 21.6% in 2021.³ **[ORGANIZATION NAME]** sees telehealth as an important tool to continue enhance access for health center patients.

[IF YOU HAVE IT, ADD MORE DETAILED INFO ON YOUR BREAKDOWN OF TELEHEALTH]

The availability of telehealth is also popular among health center patients. Results from a new NACHC survey show that almost 90% of patients surveyed agreed that telehealth addressed their needs, was suitable for interaction with their clinician, and that they were generally comfortable and satisfied with care via telehealth. A quarter of the patients surveyed had a visit for behavioral health – 52.55% via audio-only and 65.7% via video (and some were both).⁴ This adds to the growing body of research about the strength of telehealth in providing clinically equivalent care⁵ besides eliciting strong

² <https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf>

³ [https://www.cdc.gov/nchs/products/databriefs/db444.htm#:~:text=From%202019%20to%202021%2C%20the%20percentage%20of%20adults%20who%20had.21.6%25%20\(Figure%201\).](https://www.cdc.gov/nchs/products/databriefs/db444.htm#:~:text=From%202019%20to%202021%2C%20the%20percentage%20of%20adults%20who%20had.21.6%25%20(Figure%201).)

⁴ <https://www.nachc.org/resource/assessing-patient-satisfaction-with-telehealth-at-community-health-centers-a-policy-brief/>

⁵ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796668>

satisfaction from patients. Further expansion of telehealth continues to connect more providers to patients and break down social drivers of health barriers for patients.

Allowing health center Medicare patients to use telehealth for medical and mental health visits helps improve access to care for those with physical impairments, increase convenience from not traveling to an office, and increased access to specialists outside of a local area, benefits that CMS has cited in the past. Health center patients deserve the same benefits, regardless of if remote access is for medical or mental health FQHC services. Additionally, while CMS has in recent issuances justified the expansion of technology-based care in the mental health realm (as opposed to the medical realm) by relying on claims data showing that telehealth was disproportionately used for mental health services during the PHE, the data upon which CMS relied reflected only services furnished by practices that bill under the PFS – not services furnished by FQHCs. Due to the barriers noted above, access to technology-based FQHC care is just as critical for medical services as for mental health services.

Proposed Changes in Behavioral Health

[ORGANIZATION NAME] supports CMS amending FQHC regulations to include Licensed Mental Health Counselors (LMHCs) and Licensed Marriage and Family Therapists (LMFTs) to generate a billable visit in Medicare and add them to the list of core Medicare providers.

Health centers treat patients for various mental health conditions, including depression and mood disorders, anxiety and PTSD, ADHD, and more. Patients visit health centers for support in recovering from substance use disorders (SUD), including medication-assisted treatment services. In 2022, health centers provided care to over 2.7 million patients with behavioral health care needs and 300,000 patients with SUD.⁶ The number of behavioral health staff at health centers has tripled over the past 10 years, reaching over 18,000 practitioners in 2022.⁷ [ORGANIZATION NAME] appreciates CMS' commitment to supporting and strengthening the Medicaid and Medicare workforce. We appreciate CMS' intentionality in amending FQHC regulations to conform with the Consolidated Appropriations Act of 2023. Amending § 405.2463 and adding LMFTs and LMHCs to the list of eligible practitioners, will allow both providers to generate a billable visit. Health centers commonly employ LMHCs and LMFTs to expand their behavioral health services. [ORGANIZATION NAME] applauds CMS' proposal including LMFTs and LMHCs as distant site practitioners to furnish services to patients via telehealth to meet patients where they are and break down barriers to accessing care.

We also appreciate CMS amending all the other FQHC statutes to include LMFTs and LMHCs in the following places:

- § 405.2448 – adding them to preventative primary services
- § 405.2411 and § 405.2446 – adding them to the scope of services furnished to an individual as an outpatient of an FQHC
- § 410.53 – defining a marriage and family therapist and § 410.54 – defining a mental health counselor

As of March 2023, HRSA calculated that 160 million Americans live in areas with mental health professional shortages; to ensure adequate supply, over 8,000 more professionals would be needed.⁸ Expanding the core Medicare provider list and allowing FQHCs to bill for their services provides a greater opportunity for health centers to expand care teams and further integrate mental health with

⁶ 2022 UDS Data (HRSA)

⁷ [2022 UDS Data \(HRSA\), lines 20 - 21](#)

⁸ <https://data.hrsa.gov/topics/health-workforce/shortage-areas>

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primary care services. Furthermore, **[ORGANIZATION NAME]** appreciates CMS' proposal that addiction counselors who meet all the requirements of LMHCs can enroll with Medicare as LMHCs. These regulatory changes will enable health centers to maximize their workforce to meet their patients' needs. We appreciate CMS' creativity in finding ways to bolster the behavioral health workforce, like allowing addiction counselors to enroll as MHCs in Medicare, as long as they meet all requirements.

[PROVIDE ANY DETAILS ABOUT HOW THE BH WORKFORCE SHORTAGE AFFECTS YOUR PATIENTS, IMPORTANT ROLE LMFTS/LMHCS HAVE PLAYED FOR YOUR PATIENTS]

[ORGANIZATION NAME] recommends that CMS consider broadening the FQHC mental health visit by adding health and behavior assessment and intervention services (HBAI) codes to the Medicare FQHC Mental Health Visits. Presently, the list of codes that qualify as Medicare FQHC mental health "visits" is narrow, limited to psychotherapy, psychoanalysis, and diagnosis of mental health conditions.⁹ **[ORGANIZATION NAME]** would recommend including codes that address FQHC/RHC services and to include the types of services commonly furnished by LMHCs and LMFTs in outpatient clinical settings, which may include group and family therapy codes. Some billing codes may need to shift from the "medical" category to the "mental health" category. **[ORGANIZATION NAME]** recommends CMS publish guidance to ensure that the HBAI codes are recognized as qualifying codes for an FQHC "mental health" visit.

"Incident to" Proposed Changes (Section 4121 of the CAA, 2023)

[ORGANIZATION NAME] supports CMS' proposed changes to a general level of supervision for behavioral health services provided "incident to" physician or NP's services.

In 2022, like many health care facilities, nearly 68% of health centers reported losing 5-25% of their workforce in the last six months. However, health centers are experiencing unique workforce challenges related to competition with larger health care organizations. In a NACHC survey, more than 50% of health centers estimate that their employees who left for a financial opportunity at a competing health care organization accepted 10-25% wage increases in competing offers.¹⁰ Amending the "direct supervision" definition to include virtual presence will allow health centers to utilize providers across multiple sites to meet growing patient demand.

[ORGANIZATION NAME] appreciates CMS' proposal to amend the regulations at § 405.2415 and § 405.2452 to clarify that the requirement of "direct supervision" may be satisfied if the supervising clinician (as defined in subsection (b) of each regulation) is either physically present or continuously present via real-time, interactive communications technology. These revisions, which are consistent with policies in the PFS regulation,¹¹ are necessary to ensure FQHCs can bill "incident to" services furnished by auxiliary personnel on the cost report.

General Care Management Code G0511 Proposed Changes

⁹ <https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf>

¹⁰ <https://www.nachc.org/wp-content/uploads/2022/03/NACHC-2022-Workforce-Survey-Full-Report-1.pdf>

¹¹ § 410.26

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[ORGANIZATION NAME] strongly supports CMS' proposal to allow FQHCs to bill for Remote Patient Monitoring/Remote Therapeutic Monitoring (RPM/RTM), Community Health Integration (CHI) services, and Principal Illness Navigation (PIN).

We appreciate CMS creating the opportunity for FQHCs to receive reimbursement for a range of services they consistently provide to their patients. Including these new services under the general care management code G0511 is a step in the right direction for FQHCs to have evidenced data on the type and intensity of services provided.

Remote Patient Monitoring (RPM)/Remote Therapeutic Monitoring (RTM)

[ORGANIZATION NAME] supports CMS' proposal to allow FQHCs to bill for RPM/RTM under G0511, the general management care code. During the COVID-19 pandemic, health centers increased the use of RPM to provide care and monitor patients' health. Both health centers and their patients have reported positive experiences with RPM. It has helped increase patient self-sufficiency and allowed patients to gain confidence in using these self-measurement tools. Many health centers have shifted to incorporate this model and use remote monitoring technology in general to stream communication and access for patients. Furthermore, health centers have been able to reimagine preventive care and chronic disease management with at-home care utilizing remote patient monitoring. With many U.S. adults delaying preventive care, and with 6 in 10 having at least one chronic condition including heart disease, cancer, and diabetes,¹² regular health management can be a matter of life and death. Community health centers serve a large population of high-risk patients who are more likely to suffer from a disproportionate array of chronic conditions. Being able to offer patients their own self-care tools and remote patient monitoring can help prevent unnecessary health problems.

[ORGANIZATION NAME] appreciates CMS permitting FQHCs to bill for this vital service under general care management.

[ADD ANY DETAILS ABOUT YOUR RPM PROGRAM, WHICH PATIENT IT BENEFITS,]

However, we urge CMS to expand the definition of RPM devices to include devices that empower patients to monitor their own health data. During the pandemic, patients utilized devices that could self-report to the physicians or allowed them to monitor their own health. These devices could include blood glucose meters and pulse oximeters. Health center personnel have helped patients understand how to properly use the device and empower patients to take a more active role in their health care. Expanding coverage to self-reporting devices would minimize patient's out of pocket costs and increase accessibility for Medicare beneficiaries. Self-monitoring monitoring blood pressure devices (SMBPs) are a good example of why self-reporting devices need to be included in the definition, so that patients can fully utilize this useful tool to monitor their blood pressure and improve their health outcomes.

Cost and coverage should not be barriers to accessing a SMBP device especially given the unique patient population health centers serve. Forty-five percent of health center patients suffer from hypertension, compared to 32% of the general population.¹³ Furthermore, health centers serve some of the nation's most vulnerable patients; 67% of health center patients live under 100 percent of the Federal Poverty Level (FPL) and 90% live under 200 percent FPL. With the growing shift towards keeping individuals in their homes and communities as they age and receive care, health centers will

¹²<https://www.cdc.gov/chronicdisease/index.htm#:~:text=Regular%20physical%20activity%20helps%20improve,fitness%2C%20and%20quality%20of%20life.&text=CDC's%20NCCDPHP%20believes%20that%20all,to%20live%20thei r%20healthiest%20life.&text=Six%20in%20ten%20Americans%20live,stroke%2C%20cancer%2C%20or%20diabetes>

¹³ <https://www.nachc.org/community-health-center-chartbook-2023/>

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need to utilize SMBP devices to better care for patients. Expanding Medicare coverage is also aligned with CMS' health equity goals as well. In CMS' 2022-2023 Framework for Health Equity, the fifth priority is to "Increase All Forms of Accessibility to Health Care Services and Coverage."¹⁴ Coverage of SMBP devices would help meet this goal by increasing access to a crucial device that helps patients take better control of their own health. **[ORGANIZATION NAME]** strongly urges CMS to allow SMBP devices, and other patient-monitored devices, to be covered and billable under Medicare as a critical patient care tool.

Community Health Integration (CHI) Services

[ORGANIZATION NAME] supports CMS' proposal to allow FQHCs to bill for CHI services under the G0511 general management care code, which will allow auxiliary personnel like CHWs to furnish key SDOH interventions after an evaluation/management visit. **[ORGANIZATION NAME]** appreciates the Administration's continued support of CHWs, especially the \$225 million in American Rescue Plan funds to help train CHWs.¹⁵ CHWs serve as key care team members at health centers; in 2022, health centers employed over 2,300 CHWs.¹⁶ They are often members from the communities where they work, making them uniquely equipped to connect patients to community-based resources and help address barriers patients face in continually accessing the care they need. CHWs may be part of the FQHC multi-disciplinary care team, and their responsibilities can include the following:

- Determining resources available in the community and completing an action plan prior to the patient visit
- Facilitating referrals to community resources based on patient needs
- Case management and follow-up between patient visits
- Health education and translation services

CHW services have been historically supported by time-limited grants from private foundations or governmental organizations that help develop and grow capacity at the health center. However, these do not deliver long-term sustainability, so we are enthusiastic for the proposed CHI services to help cover more of these previously non-reimbursable CHW services.

[DISCUSS MORE SPECIFICS OF THE IMPORTANCE OF CHWS FOR YOUR ORG]

[ORGANIZATION NAME] recommends that the initial billing code for CHI services, GXXX1, be changed to the range of 20-60 minutes instead of just 60 minutes. We appreciate CMS' creation of two different codes – GXXX1, 60 minutes/month and GXXX2 – additional 30 minutes/month to document and bill for CHI services. However, if auxiliary personnel providing CHI services do not meet that 60-minute threshold for the visit, FQHCs are unable to bill for that visit. As previously mentioned, many health center patients have complex needs, and meeting these needs will take varying amounts of time depending on the level of services needed. Health centers need the flexibility to tailor visits to the patient's needs without health centers missing the opportunity to receive reimbursement for these eligible services. Therefore, we recommend that code GXXX1 be changed to 20-60 minutes, while maintaining GXXX2 as an additional 30 minutes/month.

As CHWs continue to be an important part of the health center care team, [ORGANIZATION NAME] advocates making CHWs a billable Medicare provider. Over the last few years, more

¹⁴ <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>

¹⁵ <https://www.whitehouse.gov/briefing-room/statements-releases/2022/09/30/fact-sheet-biden-harris-administration-announces-american-rescue-plans-historic-investments-in-community-health-workforce/>

¹⁶ <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2022>

health centers have entered contractual agreements with managed care plans that provide reimbursement based on patient size or outcomes. A 2017 Kaiser Family Foundation survey of Medicaid managed care organizations found that 67% of plans used CHWs to address social determinants of health in the previous 12 months.¹⁷ While CHWs have traditionally not been reimbursed by public and private insurers, a growing number of states are using funding mechanisms such as Medicaid State Plan Amendments, Section 1115 Demonstration Waivers, and legislative statutes to reimburse for CHW services.

We are excited for Medicare Part B to cover CHI services, including CHW services. Reimbursement for responding to SDOH needs is crucial as more FQHCs seek to transition to alternative payment models (APMs), such as participating in the recently announced Making Care Primary model.¹⁸ Health centers need payment models that will provide adequate financial support and flexibility to deliver the kind of whole-person care their patients deserve in new and innovative ways. In the end, every patient, practice, and community is different. There is no one-size-fits-all approach to addressing individuals' unique health-related social needs. Employing CHWs at the health center is one way to provide help and resources to patients, and getting reimbursement for CHI services, and hopefully coverage of CHWs as a billable Medicare provider, will help health centers continue to employ CHWs.

Furthermore, **[ORGANIZATION NAME]** recommends that CMS not limit only one practitioner to furnish and bill the CHI initiating visit and the CHI services for a patient. At FQHCs, located in health professional shortage areas (HPSAs), physicians and non-physician practitioners operate as care teams. As a result, the patient may be seen by more than one provider in a group practice, with each provider following the shared care plan within the care team. When multiple providers, in a group practice, operate as a clinical care team, each provider in the group practice would be working in support of the same clinical care plan. This means the provider who conducts the CHI initiating visit may not always be the same provider providing the CHI services, in a group practice environment. Alternatively, one or more of the providers, in the same group practice, may conduct the initiating visit and a different provider in the group may oversee the subsequent CHI services. We feel strongly believe that limiting the CHI initiating visit and CHI services to the same individual provider, without recognition of group practices that employ other practitioners that may initiate the qualifying visit, would impair the ability of auxiliary personnel to provide CHI services to patients.

Principal Illness Navigation (PIN) Services

[ORGANIZATION NAME] supports adding Principal Illness Navigation (PIN) services to the general care management HCPCS code G0511 to allow FQHCs to bill for providing specific care services to patients with high-risk conditions. CMS defines providing PIN services “to help people with Medicare who are diagnosed with high-risk conditions — e.g., cancer, mental health conditions, substance use disorder (SUD) — identify and connect with appropriate clinical and support resources.” These services will focus on patients whose diagnosis is expected to last at least three months.

Similar to our comments on CHI, **[ORGANIZATION NAME]** recommends that GXXX3, be changed to 20-60 minutes instead of 60 minutes/month. CMS needs to give health centers the flexibility to meet the needs of the patient, and not an arbitrary timeline. Health center patients qualifying for these PIN services might need quick touch points to connect them to the services they need or longer visits, depending on the services provided. Given health centers' experience with

¹⁷ <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

¹⁸ <https://innovation.cms.gov/innovation-models/making-care-primary>

patients who would benefit from PIN services, it should be up to the health centers' judgment how long they need to spend with patients and connecting them to services, and they should still be reimbursed for those services. To ensure that FQHCs are able to accurately bill for patient encounters, we recommend that code GXXX3 be changed to 20-60 minutes, while maintaining GXXX4 as an additional 30 minutes/month.

Proposed Revision to the Calculation of the Payment Amount for the General Care Management HCPCS Code G0511

[ORGANIZATION NAME] appreciates CMS' recommendation to change HCPCS code G0511 calculation to support adequate payment for general care management, and recommends including GBHI and CPM in the weighted calculation.

We agree that utilizing a weighted average of the services under code G0511 will better demonstrate true utilization of these services. While the code will reimburse \$72.98 in CY24, a decrease from the 2023 reimbursement rate, the true average methodology would have resulted in a much lower reimbursement rate, as explained in the proposed rule. However, **[ORGANIZATION NAME]** requests that CMS add the General Behavioral Health Integration (GBHI) code and the Chronic Pain Management (CPM) codes into the weighted average for the calculation of G0511. In the CY23 Medicare Physician Fee Schedule, CMS expanded the general care management suite and added Chronic Pain Management (CPM) and General BHI (GBHI) to the list of codes under G0511. We advocate that their inclusion in the weighted calculation will provide a more accurate reimbursement and better picture of utilization of the suite of services FQHCs provide under this code.

Chronic Care Management Services – Beneficiary Consent & Virtual Communication Services

[ORGANIZATION NAME] supports CMS' proposal to increase the ways providers can obtain patient consent for chronic care management (CCM) services.

Due to COVID-19 flexibilities permitted by CMS, health centers were able to obtain patient consent in a variety to ensure patients could continue receiving chronic care management services. We appreciate CMS clarifying that health centers can continue using these options, including verbally (if documented in the medical record), by auxiliary staff performing CCM service, or via virtual communication by auxiliary staff under general supervision. This flexibility will continue to allow health centers to enhance their efficiency by tailoring their operational processes and workflows to continue focusing on patient care. We also appreciate CMS allowing third-party vendors to obtain consent from patients. Utilizing technological third-party vendors helps decrease administrative burden, allowing health center personnel more time to focus on providing patient care while ensuring patients' understanding of services rendered.

Medicare Diabetes Prevention Program Expanded Model (MDPP):

[ORGANIZATION NAME] supports being able to allow MDPP suppliers to continue offering MDPP services virtually using distance learning delivery through December 31, 2027, if they maintain an in-person CDC organization code.

Twenty-one percent of health center patients have diabetes, compared to 11% of the general U.S. population. Yet, health centers are able to achieve higher rates of diabetes control compared to the national average. Thirty-two percent of health center patients have their diabetes under control versus 19% of the general US population with diabetes.¹⁹ Health centers are naturally able to strategically

¹⁹ <https://www.nachc.org/community-health-center-chartbook-2023/>

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help diabetic patients manage their diabetes, due to their focus on primary, preventative, and public health education services. **[ORGANIZATION NAME]** supports continuing to allow the following flexibilities to bridge care gaps for patients and give MDPP suppliers the flexibility to reach more patients:

- The collection of weight measurements for MDPP beneficiaries via virtual technology and/or self-reported weight measurements
- Beneficiaries to access all MDPP services virtually, with no maximum of virtual sessions provided
- MDPP providers to bill for each session attended (up to 22 sessions over the 12-month MDPP services period).

[IF YOU'RE AN MDPP SUPPLIER/PROVIDER, ADD MORE DETAILS ON ITS BENEFITS TO YOUR PATIENTS]

Proposal to Create Reimbursement for SDOH Risk Assessment

[ORGANIZATION NAME] supports CMS' proposal to reimburse for the screening of social drivers of health (SDOH) through the creation of a standalone G code but urges the agency to clarify language to ensure FQHCs can benefit from this proposal.

Health centers have long been at the forefront for screening for SDOH and subsequently connecting patients to these resources. Health centers were created to specialize in providing comprehensive primary care services. From the onset, health center practitioners have provided whole-person care when treating their patients, uncovering barriers patients face in accessing basic health care services. With their team approach to care, health centers saw the need to document and track these services to ensure that any provider treating the patient can fully understand their needs.

One of the tools that health centers use is the Protocol for Responding and Assessing Patients' Assets, Risks and Experiences (PRAPARE) tool. NACHC helped create this tool to enable health centers and other providers to collect the data they need to better understand and address their patients' social determinants of health.²⁰ In 2022, 599 health centers used the PRAPARE tool, which was mentioned in this NPRM as an accepted tool to use when conducting an SDOH risk assessment. Furthermore, 28% of health centers have reported that they are in the planning stage of getting a tool to complete screening for SDOH health risk assessment.²¹

[IF YOU USE PRAPARE, DISCUSS MORE ABOUT ITS BENEFITS TO YOUR ORG AND PATIENTS]

[ORGANIZATION NAME] recommends CMS amends the regulation to allow FQHCs to be reimbursed for this evaluation. Additionally, **[ORGANIZATION NAME]** recommends that the number of minutes in the new stand-alone G code be increased from 5-15 minutes to 10-20 minutes to give staff adequate time to engage with their patients. As currently proposed, this new stand-alone G code, GXXX5, would allow providers to bill 5-15 minutes every 6 months, for the administration of a standardized, evidence-based SDOH Risk Assessment. The PRAPARE tool takes approximately 9 minutes to complete, if the practitioner is quickly asking the questions and leaving little room for prolonged dialogue. More than 9 minutes are needed to have a truly bidirectional conversation with the patient. Talking about SDOH needs can be sensitive and health center care team

²⁰ <http://nachc.org/research-and-data/prapare/>

²¹ <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=EHR&year=2022>

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members strive to make the patient feel comfortable talking about their lived experiences and needs. In order to best address patient SDOH needs, more time is needed for this risk assessment. Health centers serve some of the most medically complex patients. Given that 80-90% of health outcomes are due to SDOH,²² health centers prioritize screening and then connecting patients to services to help address SDOH.

[ORGANIZATION NAME] strongly encourages CMS to adopt more flexible policies that reimburse health centers for follow-up visits after a patient has a positive screen for SDOH needs. Additionally, it's important the CHC has the discretion to determine how often a patient should be screened. We advocate for the development of billing codes that reflect the time and effort health center care team members invest in not only assessing patients, but connecting those patients to crucial services. We also recommend CMS create billing codes that support care coordination efforts aimed at addressing SDOH. This could include reimbursement for activities like connecting patients with community resources, coordinating with social workers, and monitoring SDOH-related interventions.

[ADD DETAILS ABOUT HOW THESE FLEXIBILITIES WILL HELP, AND HOW IT WILL MITIGATE FINANCIAL BARRIERS FOR YOUR ORG/PATIENTS, WHAT TYPES OF SDOH NEEDS YOUR PATIENTS FACE]

We also support the proposal to add the new SDOH code to the Medicare Telehealth Services List. Until December 31, 2024, FQHCs will be able to bill for any service on the telehealth list under the G2025 code, including this SDOH code. We urge CMS to allow FQHCs to bill for telehealth services beyond the 2024 deadline. Telehealth has played a vital role for health centers during and after the pandemic. This would allow health centers that allow practitioners, or auxiliary personnel, to continue to complete the risk assessment in an interview format, depending on patient needs. Allowing health centers the flexibility in furnishing this risk assessment will help them better meet the needs of their patients. For example, a health center may conduct this health risk assessment over the phone and then use their E/M visit to dive more deeply into the areas of concern flagged during the telephonic risk assessment.

Furthermore, **[ORGANIZATION NAME]** advocates for more federal support of PRAPARE. There is currently a lack of federal funding to assist health centers in covering the cost of integrating PRAPARE into their EHRs, which could cost anywhere from \$6,000 to over \$49,000.²³ Health centers operate on thin financial margins and while many health centers already screen for SDOH, there are other smaller health centers whose budgets cannot absorb the cost of integrating PRAPARE into EHRs. **[ORGANIZATION NAME]** supports additional federal funding to help health centers cover the administrative costs of integrating PRAPARE into their clinics and the costs to cover the services needed for patients after they are identified by PRAPARE.

Proposal to Include an Optional, Additional, Social Determinants of Health Risk Assessment in the Annual Wellness Visit

[ORGANIZATION NAME] supports CMS' proposal to reimburse for an SDOH Risk Assessment as part of the Annual Wellness Visit (AWV) but asks CMS to clarify language to ensure FQHCs can bill for this optional, additional service.

As mentioned above, health centers are consistently screening and addressing patients' SDOH needs. Screening for SDOH can happen during a variety of times. For new patients, health centers complete

²² <https://www.nejm.org/doi/full/10.1056/NEJMSa073350>

²³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9996544/>

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an initial assessment for a patient and then it happens at least annually. Having the risk assessment be part of the AWV naturally fits with how many health centers already operate these visits. We also support the idea that like the AWV, the SDOH Risk Assessment will not cost patients anything when paired with the AWV. However, it is unclear how health centers would be getting paid for administering this additional, optional risk assessment.

[ADD MORE DETAILS ABOUT HOW YOU CONDUCT YOUR AWV, HOW ADDING THIS COULD POSITIVELY IMPACT YOUR PATIENTS]

[ORGANIZATION NAME] seeks clarification that FQHCs would be eligible to bill for this; we propose being able to receive payment for the SDOH Risk Assessment as an additional adjuster, similar to how FQHCs currently get paid for conducting the AWV. Health centers are required under § 410.15 to conduct an AWV for Medicare patients and receive a 34.16% payment increase under Medicare's FQHC PPS G Codes for new patients.²⁴ Allowing health centers to get paid for the SDOH risk assessment through an additional adjuster will help health centers continue to provide the assessments and further incentivize smaller health centers with smaller operating budgets to more formally assess and document SDOH needs of their patients.

Dental and Oral Health:

[ORGANIZATION NAME] applauds CMS' proposal to expand payment under Medicare Parts A and Part B by amending the regulation at § 411.15(i)(3)(i)(A) for certain dental and oral health services in relation to Medicare-covered treatments for head and neck cancer. We urge that the list of billable visit codes modified in this proposed rule be included in the dental bundle for FQHCs.

We appreciate that this proposal further builds upon the CY23 Physician Fee Schedule, which rectified Medicare's previous lack of dental coverage. Permitting Medicare Parts A and B payment for dental or oral examinations, medically necessary diagnostic and treatment services, and services ancillary to those listed above, such as x-rays and anesthesia, in the treatment of cancer with chemotherapy, CAR T-cell therapy, and high-dose bone-modifying agents (antiresorptive therapy) will help address persistent inequities in cancer outcomes. One in five Medicare patients spend over \$1000 on dental-related procedures,²⁵ so we are excited to see how this will improve health outcomes and affordability for older adults and people with disabilities undergoing treatment for various types of cancer.

We agree with the proposed rule that these dental and oral health services should be covered regardless of whether they are offered in inpatient or outpatient settings. We are additionally pleased that CMS is clarifying that these proposals will cover dental and oral health treatments and ancillary services prior to or during cancer treatment as well as regardless of primary or metastatic status, site of origin, or initial treatment modality. We further appreciate the clarification that this coverage applies to dental services related to chemotherapy regardless of whether or not chemotherapy is used in combination with other cancer therapies. If this were to only apply in cases where chemotherapy is the only treatment, we fear it would increase health disparities between cancer treatments. For example, patients have different survival rates undergoing chemotherapy plus radiotherapy treatment for early-stage Hodgkin Lymphoma compared to those only receiving chemotherapy treatments.²⁶ These patients should all benefit from covered dental and oral health services.

²⁴ Medicare Benefits Policy Manual, Chapter 13, Section 70.3.

²⁵ <https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/>

²⁶ <https://www.breastcancer.org/managing-life/immune-system/cancer-treatments/radiation-therapy>

As with the other services discussed in these comments, for dental services, it is critical that CMS consider FQHCs' unique Medicare payment structure, to ensure policy changes for FQHCs are analogous to any changes made under the PFS. Around 82% of health centers provide dental services on-site and health center patients could benefit from this proposal, as long as FQHC billing codes are edited in tandem. We note that the "physicians' services" component of the Medicare FQHC benefit includes services furnished by dentists. **[ORGANIZATION NAME]** urges CMS to modify the list of billable visit codes modified in this proposed rule to be included in the dental bundle alongside any expansion in codes recognized under the PFS for dental-related services.

Medicare Request for Information:

Requiring Patient Consent for CHI Services

[ORGANIZATION NAME] recommends CMS adopt a policy that permits providers collect patient consent for CHI service on an annual basis. However, we do not believe patient consent needs to be obtained every time auxiliary personnel provide CHI services, given that staff providing these services do frequently interact with the patient either in-person or over the phone, depending on the services. This is in-line with current protocol for patients receiving most care management services to ensure patients understand costs associated with services performed, as CMS stated in the proposed rule. Furthermore, this aligns with the overarching Administration's goal to decrease surprise medical bills writ large. Patients need to be made aware prior to receiving CHI services that they are responsible for any cost-sharing obligations. This could be done during the initial evaluation/management visit with the health center billing practitioner and reconfirmed on a yearly basis either at another in-person visit or virtually.

Ways to Increase Access to Behavioral Health Integration (BHI) Services

[ORGANIZATION NAME] supports CMS' idea to allow interprofessional consultation to be billed by practitioners authorized by statute for the diagnosis and treatment of mental illness. The CPT codes would need to be added to an FQHC qualifying visit and the specific providers to the core providers list. These interprofessional consultant codes are already established in Medicare and also align with CMS' efforts in the Medicaid space. This past January, a State Health Official (SHO)²⁷ 23-001 letter explained how interprofessional consultative providers in Medicaid can be directly paid, superseding previous policy where the treating practitioner (for example, an FQHC) was paid an increased rate for a covered Medicaid service. Previously, the treating practitioner then paid the consulting practitioner out of that payment rate through a separate arrangement between the two providers. Crafting ways to better utilize interprofessional consultations will help enhance care coordination efforts. However, health centers are not able to take advantage of these opportunities fully in the Medicare space.

We know that CPT codes already allow for the use of interprofessional internet consults codes (99446 – 99451) for practitioners such as NPs, physicians, and psychiatrists for other health care providers in the fee schedule. For FQHCs to take advantage of these interprofessional consultations, **[ORGANIZATION NAME]** advocates for these codes be added on the FQHC qualifying visit list.²⁸ Furthermore, CMS would need to add the clinical social workers, clinical psychologists, psychiatrists, clinical nurse specialists, NPs, PAs, and Certified Nurse Midwives (CNM) to the core providers list for interprofessional consults to generate a separate billable visit. Allowing more

²⁷ https://www.medicaid.gov/sites/default/files/2023-01/sho23001_0.pdf

²⁸ <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf>

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behavioral health specialists to share their expertise through interprofessional consultation will help achieve better health care outcomes. Interprofessional consultation could be useful for Medicare health center patients, such as when a health center practitioner consults with a psychiatrist on medication management when a patient is not able or willing to seek care directly from the specialist. Additionally, interprofessional consultations can enhance timely access to mental and behavioral care services, lessen the need for in-person referral or visit, allow for shorter wait times, and support team-based care.²⁹ Utilizing interprofessional consultation is a step towards better utilizing BHI services.

[ORGANIZATION NAME] advocates for better reimbursement for behavioral health interventions provided in the primary care setting using a SBIRT model. Health centers could more successfully integrate BH into primary care if reimbursement were increased to provide brief interventions to prevent need for additional more intensive supports, or to improve treatment outcomes and follow up engagement in care. For example, a psychologist may spend significant time helping the patient select treatment facilities or overcome barriers to treatment such as cost or transportation to the specific setting.³⁰ Currently, FQHCs and Medicare providers are reimbursed for SBIRT services through CPT codes G0396/G0397, which deals with alcohol and/or substance (other than tobacco) misuse structured assessment. However, health centers are not reimbursed for any of the interventions or efforts made to connect them to the best treatment. **[ORGANIZATION NAME]** recommends expanding the coding list to increase the number of ways FQHCs can get reimbursed for SBIRT, which will also help better accurately document the ways in which FQHCs are utilizing SBIRT for their patients.

[DISCUSS HOW YOU USE THE SBIRT MODEL, IF APPLICABLE]

[ORGANIZATION NAME] also supports CMS enhancing flexibilities for medical visits and mental health visits performed on the same day, which could better integrate BHI into the primary care setting.

It is difficult to meet the requirements of both a medical visit and mental health visit to generate two separate billable visits. Currently, under 405.2463(b) defines an FQHC medical visit needing to be a “face-to-face encounter.” For example, a patient could have a qualifying medical visit with a physician, NP, or PA. The practitioner then decides that the patient needs to see a clinical psychologist for a medication adjustment that same day. However, given that medication management does not qualify as a stand-alone mental health visit in a FQHC, no claim is submitted, and no payment is made for this service.³¹ The mental health provider would need to provide services based on one of the following CPT codes: 90791, 90792, 90832, 90834, 90837, 90839, or 90845 in order to be able to add the charge to the claim. This example showcases a barrier health centers face in attempting to fully integrate behavioral health into primary care.

[DISCUSS HOW THIS BARRIER HAS IMPACTED YOUR ORG/PATIENTS, HOW YOU TRY TO INTEGRATE BH INTO YOUR ORG]

Request for Information: Definition of “Nurse Practitioner”

²⁹ <https://www.apaservices.org/practice/reimbursement/health-codes/interprofessional-record-health-consultations#:~:text=Interprofessional%20consultation%20services%20offer%20several,team%2Dbased%20approach%20to%20care.>

³⁰ <https://www.apaservices.org/practice/reimbursement/health-codes/substance-alcohol-abuse-services>

³¹ <https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-faqs.pdf>

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[ORGANIZATION NAME] supports a broad definition of a nurse practitioner (NP) at § 491.2(1) certification requirements to allow health centers to employ NPs who can best serve their patient population.

As mentioned previously, like the rest of the health care system, health centers are experiencing a workforce shortage. At the beginning of 2022, nearly 68% of health centers reported losing 5-25% of their workforce. In 2022, over 12,000 NPs played key roles as part of the care team at health centers.³²

[ORGANIZATION NAME] supports the inclusion of the educational requirements in the definition but do not see it necessary to include specific certification requirements. We advocate for health centers to be able to hire NPs based on the patient population their health center serves. For example, there are critical roles that a psychiatrist NP or NP addiction specialist hold in a health center care team. Furthermore, many NPs get further training in a specific area to better support their patients (e.g. geriatrics, neonatal, pediatric acute care), which may or may not result in a certification. There are health centers that have embraced fellowships, training, or residency programs for newer NPs to ensure that they have the opportunity to develop the skills as well.³³ Additionally, many states have further licensure requirements to ensure patient safety. We support CMS allowing health centers to hire NPs based on their patient population as well as the NPs' individual skills and trainings and do not believe a certification requirement is necessary at this time, especially since 88% of licensed NPs in the U.S. are educated and prepared in primary care.³⁴

[PROVIDE MORE DETAILS ABOUT THE TYPES OF CREDENTIALING/EDUCATION YOU OFFER NPS, HOW THEY HELP YOUR WORKFORCE ETC]

Thank you for your consideration of these comments on the FQHC portion of the Medicare Physician Fee Schedule, as well as areas we hope FQHCs can take part in. If you have any questions, please contact **YOUR POLICY DIRECTOR'S NAME & EMAIL**

Sincerely,

NAME OF ORGANIZATION LEADER

TITLE

³² <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2022>

³³ <https://www.chc1.com/what-we-do/training-the-next-generation/residency-training-programs/> ;
<https://www.unityhealthcare.org/training-education/family-nurse-practitioner-residency>

³⁴ <https://www.aanp.org/advocacy/advocacy-resource/position-statements/nurse-practitioners-in-primary-care#:~:text=Millions%20of%20Americans%20choose%20a>