



September 11, 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:

The National Association of Community Health Centers (NACHC) is the national membership organization for federally qualified health centers (also known as FQHCs or health centers). Health centers are federally-funded or federally recognized nonprofit, community-directed provider clinics that serve as the health home for over 31 million people, including 1 in 6 Medicaid and over 3 million elderly patients. It is the collective mission and mandate of over 1,400 health centers around the country to provide access to high-quality, cost-effective primary and preventative medical care as well as dental, behavioral health, and pharmacy services and other “enabling” or support services that facilitate access to care to individuals and families located in medically underserved areas, regardless of insurance status or ability to pay.

The number of health center Medicare patients has increased significantly over the past ten years, from 1.5 million in 2010 to 3.3 million in 2022, currently making up 11% of patients health centers serve. Health centers play an integral role in helping lower out-of-pocket costs for Medicare patients. For example, areas with high health center penetration have 10% (\$926) lower Medicare spending per beneficiary. This could be attributed to the health center model of care that strives to provide Medicare patients with affordable and high-quality care.

NACHC supports CMS’ proposals to expand coverage and billing of Medicare services to serve our patients better. We appreciate CMS’ efforts to expand access to care with a health equity lens. NACHC 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.

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

- NACHC supports CMS’ regulatory change to harmonize in-person requirements for mental health telehealth visits with the Consolidated Appropriations Act of 2023 (CAA 2023).

- NACHC strongly urges CMS to revise the FQHC medical visit definition to avoid significant gaps in care for some of the most vulnerable Medicare patients.
- NACHC 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.
- NACHC supports CMS' proposed changes to a general level of supervision for behavioral health services provided "incident to" physician or Nurse Practitioner's (NP) services.
- NACHC 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).
- NACHC appreciates CMS' recommendation to change the HCPCS code G0511 calculation to support adequate payment for general care management and recommends including General Behavioral Management Integration (GBMI) and Chronic Pain Management (CPM) in the weighted calculation.
- NACHC supports CMS' proposal to increase the ways providers can obtain patient consent for chronic care management (CCM) services.
- NACHC supports CMS permitting Medicare Diabetes Prevention Program (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.
- NACHC supports the new G code for screening social drivers of health (SDOH) and urges CMS to create more flexibility for providers to tailor services to meet patients' unique needs.
- NACHC supports CMS' proposal to reimburse for an SDOH Risk Assessment as part of the Annual Wellness Visit and requests CMS amend their proposal to ensure FQHCs can bill for this optional, additional service.
- NACHC 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.
- NACHC recommends CMS adopt a policy that permits providers to collect patient consent for CHI service annually.
- NACHC supports CMS' idea to allow interprofessional consultation to be billed by practitioners authorized by statute for the diagnosis and treatment of mental illness. If implemented, CMS would need to add the CPT codes to an FQHC qualifying visit and the specific providers to the core providers list.
- NACHC 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

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

NACHC 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 NACHC 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

NACHC strongly urges CMS to revise the FQHC medical visit definition 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 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 permits patients to receive all health center services virtually.

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. **NACHC encourages CMS to use its authority vested by Congress to broaden the FQHC visit definition to include virtual capabilities for medical visits.**

NACHC 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 throughout the pandemic – the percentage of adults who sought out mental health treatment increased from 19.2% in 2019 to 21.6% in 2021.³ NACHC sees telehealth as an essential tool to continue increasing access for health center patients.

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

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

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).)

needs, was suitable for interaction with their clinician, and 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 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, minimizes transportation and work schedule barriers, and increases access to specialists outside of a local area. Health center patients deserve the same benefits, regardless of whether remote access is for medical or mental health FQHC services. NACHC encourages CMS to create more opportunities for health centers to collect data on the utilization of telehealth for FQHC medical visits to further demonstrate the high quality of care delivered until December 2024. Currently, CMS only evaluates data for other types of providers, which does not reflect health centers' 31.5 million patients. **NACHC strongly urges CMS to revise the FQHC medical visit definition to ensure our patients have access to health center services through the modality of their choice.**

Proposed Changes in Behavioral Health

NACHC 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, Post-Traumatic Stress Disorder (PTSD), Attention-Deficit / Hyperactivity Disorder (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 ten years, reaching over 18,000 practitioners in 2022.⁷ NACHC 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. NACHC 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

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>

⁶ 2022 UDS Data (HRSA)

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

- § 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 primary care services. Furthermore, NACHC appreciates the agency’s 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.

NACHC recommends CMS revise the FQHC mental health “visit” definition at 42 CFR 405.2463(b)(3) to allow certain trainees to provide behavioral health services under the general supervision of a provider. Through the changes to the “incident to” rules in the Physician Fee Schedule (PFS), other types of providers are allowed to have clinician trainees delivering behavioral health services under the general supervision of the supervisor. This is due to changes under CY23 PFS, where CMS changed the rules to allow for general supervision, instead of direct supervision, of behavioral health services. Unfortunately, this change cannot grant FQHC trainees the same benefits. We appreciate CMS’ proposal to make similar revisions to the “incident to” rules in the FQHC regulations at 42 CFR Pt 405, Subpart X. However, these proposed revisions do not achieve the same result because FQHCs cannot bill for a service rendered by the trainee due to the application of the “visit” definition.

Health centers have the same struggles with trainees. Capable behavioral health clinicians have degrees but must complete their 3,000 hours of clinical supervision. Hiring these clinicians right out of school is a great pathway to strengthen the behavioral health workforce. Health centers can provide them with training and then fully hire these behavioral health clinicians once they complete their supervision hours. However, the current Medicare payment methodology poses an obstacle. Health centers cannot bill Medicare for a “visit” when a trainee provides a psychotherapy session under the general supervision of a fully licensed clinician because it is an “incident to” service. Although Medicare comprises only a small portion of patients, it is the fastest-growing patient population for health centers, increasing 147% from 2010 to 2021.⁹

Furthermore, it can be difficult for health centers to route patients to clinicians based on their form of coverage. This is especially relevant given the realities of the clinician workforce shortages in both urban and rural areas nationwide.¹⁰ The proposed changes in the “incident to” rules¹¹—changing the required level of supervision for behavioral health services furnished “incident to” a

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

⁹ <https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf>

¹⁰ <https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage>

¹¹ § 405.2413

physician or NP’s services at FQHCs to allow general supervision¹²— do not provide relief for this issue because billable units of service still must include direct involvement by the core clinician. **To account for the trainee’s time, NACHC is requesting CMS to permit health centers to bill their PPS rate for trainees’ visits that occur under the general supervision of a billable provider.** CMS has the authority to revise the FQHC mental health visit definition to reflect the regulatory flexibility other providers have while trainees complete their clinical supervision.

NACHC 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.¹³ NACHC would recommend including codes that address FQHC/RHC services and include the types of services commonly furnished by LMHCs and LMFTs in outpatient clinical settings, which may consist of group and family therapy codes. Some billing codes may need to shift from the “medical” category to the “mental health” category. NACHC 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)

NACHC supports CMS’ proposed changes to a general level of supervision for behavioral health services provided “incident to” physician or Nurse Practitioner’s (NP) 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.¹⁴ Amending the “direct supervision” definition to include virtual presence will allow health centers to utilize providers across multiple sites to meet growing patient demand.

NACHC 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,¹⁵ are necessary to ensure FQHCs can bill “incident to” services furnished by auxiliary personnel on the cost report.

¹² This is consistent with the policies finalized under the PFS for CY 2023.

¹³ <https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf>

¹⁴ <https://www.nachc.org/wp-content/uploads/2022/03/NACHC-2022-Workforce-Survey-Full-Report-1.pdf>

¹⁵ § 410.26

General Care Management Code G0511 Proposed Changes

NACHC 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)

NACHC 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 using these self-measurement tools. Many health centers have shifted to incorporate this model and use remote monitoring technology in general to streamline 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 6 in 10 having at least one chronic condition, including heart disease, cancer, and diabetes,¹⁶ 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. Offering patients self-care tools and remote patient monitoring can help prevent unnecessary health problems. NACHC appreciates CMS permitting FQHCs to bill for this vital service under general care management.

To ensure health center patients have access to various RPM services, we urge CMS to expand the definition of RPM devices to include devices that empower patients to monitor their health data. During the pandemic, patients used devices that could self-report to the physicians or allow them to monitor their 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 valuable tool to monitor their blood pressure and improve their health outcomes.

Cost and coverage should not be barriers to accessing an SMBP device, especially given the unique patient population health centers serve. Forty-five percent of health center patients suffer from

¹⁶<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%20their%20healthiest%20life.&text=Six%20in%20ten%20Americans%20live,stroke%2C%20cancer%2C%20or%20diabetes>

hypertension, compared to 32% of the general population.¹⁷ 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 need to utilize SMBP devices to better care for patients. Expanding Medicare coverage is 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."¹⁸ Coverage of SMBP devices would help meet this goal by increasing access to a crucial device that helps patients better control their health. NACHC 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.

NACHC recommends CMS allow a co-insurance waiver for FQHC patients using RPM devices. While most Medicare patients do not have to pay for RPM devices, they are still responsible for a 20% co-insurance payment. Patients should not have to choose between crucial RPM services and necessities such as food, housing, and transportation. Waiving co-insurance costs of RPM for FQHC patients alleviates potential financial barriers to care and increases affordability for this vital service. **NACHC recommends CMS amend the frequency FQHCs can bill for RPM services, basing it on a calendar month rather than every 30 days.** CMS proposes to base RPM on a 30-day timeline, whereas Chronic Care Management (CCM) services are based on the calendar month. Having CCM and RPM be based on the calendar month will alleviate the administrative burden and better align these two services, which fall under the general care management code G0511. CMS would need to specify this change in HCPCS codes 99454 and 99091 for RPM.

Community Health Integration (CHI) Services

NACHC supports CMS' proposal to allow FQHCs to bill for CHI services under the G0511 general management care code, enabling auxiliary personnel like Community Health Workers (CHWs) to furnish critical SDOH interventions after an evaluation/management visit. NACHC appreciates the Administration's continued support of and funding for CHWs. CHWs serve as key care team members at health centers. In 2022, health centers employed over 2,300 CHWs.¹⁹ They are often members from their communities, 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 before 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.

¹⁷ <https://www.nachc.org/community-health-center-chartbook-2023/>

¹⁸ <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>

¹⁹ <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2022>

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 about the proposed CHI services to help cover more of these previously non-reimbursable CHW services.

NACHC 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 – an 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 a visit, FQHCs cannot 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 missing the opportunity to receive reimbursement for these eligible services, and this should include shorter check-ins to keep patients on track. 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 essential part of the health center care team, NACHC strongly urges CMS to make CHWs a billable Medicare Part B provider. Over the last few years, more 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.²⁰ 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 and Medicare Shared Savings Program.²¹ 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 health centers is one way to provide help and resources to patients and reimbursement for CHI services. Coverage of CHWs as a billable Medicare provider will support health centers and CHWs long term.

Furthermore, NACHC recommends that CMS permit more than one practitioner to furnish and bill the CHI-initiating visit and the CHI services for a patient to support care team flexibility. 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

²⁰ <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/>

²¹ <https://innovation.cms.gov/innovation-models/making-care-primary>

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 providers in the same group practice may conduct the initiating visit, and a different provider in the group may oversee the subsequent CHI services. 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

NACHC supports adding Principal Illness Navigation (PIN) services to the general care management HCPCS code G0511 to allow FQHCs to bill for specific care services to patients with high-risk conditions. CMS defines providing PIN services as “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.

Like our comments on CHI, NACHC recommends that GXXX3 be changed to 20-60 minutes instead of 60 minutes/month. Health centers need the flexibility to meet patient’s needs and should not be restricted by an arbitrary timeline. Health center patients qualifying for these PIN services might need quick touchpoints to connect them to the services they need or longer visits, depending on the services provided. Given health centers’ experience with 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 connect them to services, and they should still be reimbursed for those services. To ensure that FQHCs can 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

NACHC appreciates CMS’ recommendation to change the HCPCS code G0511 calculation to support adequate payment for general care management and recommends including General Behavioral Management Integration (GBHI) and Chronic Pain Management (CPM) in the weighted calculation.

Utilizing a weighted average of the services under code G0511 will better demonstrate the 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, NACHC 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 Behavioral Health Integration (GBHI) to the list of codes under G0511. NACHC believes that their inclusion in the weighted calculation

will provide a more accurate reimbursement and better picture of the utilization of the suite of services FQHCs provide under this code.

Chronic Care Management Services – Beneficiary Consent & Virtual Communication Services
NACHC 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 could obtain patient consent in various ways 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. NACHC also appreciates CMS permitting 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 patient care while ensuring patients understand the services rendered.

Medicare Diabetes Prevention Program Expanded Model (MDPP):
NACHC supports CMS permitting Medicare Diabetes Prevention Program (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 U.S. population with diabetes.²² Health centers are naturally able to strategically help diabetic patients manage their condition due to their focus on primary, preventative, and public health education services. NACHC supports extending 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 being able 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).

Proposal to Create Reimbursement for SDOH Risk Assessment

NACHC supports the new G code for screening social drivers of health (SDOH) and urges CMS to create more flexibility for providers to tailor services to meet patients’ unique needs.

²² <https://www.nachc.org/community-health-center-chartbook-2023/>

Health centers have long been at the forefront of screening for SDOH and connecting patients to these resources. Health centers specialize in providing comprehensive primary care services through whole-person care when treating patients and 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 understand better and address their patients' social determinants of health.²³ In 2022, nearly 600 health centers used the PRAPARE tool, which was mentioned in this NPRM as an accepted tool for 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.²⁴

NACHC recommends increasing the number of minutes in the new standalone G code from 5-15 minutes to 10-20 minutes to give staff adequate time to engage with their patients. As proposed, this new standalone G code, GXXX5, would allow providers to bill 5-15 minutes every six months to administer a standardized, evidence-based SDOH Risk Assessment. The PRAPARE tool takes approximately 9 minutes to complete if the practitioner quickly asks the questions and leaves little room for prolonged dialogue. More than 9 minutes are needed for a meaningful bidirectional conversation with the patient. Discussing SDOH needs can be a sensitive conversation, and health center care team members strive to make patients feel comfortable when sharing their lived experiences and needs. To best address patient SDOH needs, more time is required 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,²⁵ health centers prioritize screening and connecting patients to services to help address SDOH.

NACHC strongly encourages CMS to adopt more flexible policies that reimburse health centers for follow-up visits after patients have a positive screen for SDOH needs. Additionally, it's important the health center has the discretion to determine how often a patient should be screened. The development of billing codes that reflect the time and effort health center care team members invest when assessing patients and connecting those patients to essential services is critical. NACHC also recommends 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.

We also support the proposal to add the new SDOH code to the Medicare Telehealth Services List. Until December 31, 2024, FQHCs can bill for any service on the telehealth list under the G2025 code, including this SDOH code. NACHC urges CMS to allow FQHCs to bill telehealth services to address SDOH beyond the 2024 deadline, given the vital role telehealth has played during and after the pandemic. This would enable health centers that allow practitioners, or auxiliary

²³ <http://nachc.org/research-and-data/prapare/>

²⁴ <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=EHR&year=2022>

²⁵ <https://www.nejm.org/doi/full/10.1056/NEJMsa073350>

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, NACHC 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 Electronic Health Records (EHRs), which could cost anywhere from \$6,000 to over \$49,000.²⁶ 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. NACHC 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 PRAPARE identifies them.

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

NACHC supports CMS' proposal to reimburse for an SDOH Risk Assessment as part of the Annual Wellness Visit (AWV) and requests CMS amend their proposal to ensure FQHCs can bill for this optional, additional service.

Screening for SDOH is embedded in the health center's mission and model of care. Screening for SDOH can happen during a variety of times. For new patients, health centers complete an initial risk assessment and then incorporate routine check-ins, every 6-12 months. The risk assessment inclusion in the AWV naturally fits within the typical health center visit. NACHC appreciates CMS recognizing that the SDOH risk assessment should be at no cost to the patient when paired with the AWV. However, how health centers would be reimbursed for administering this additional, optional risk assessment is unclear.

NACHC strongly urges CMS to create an additional SDOH risk assessment adjuster under the AWV to create additional reimbursement when using an SDOH tool. 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.²⁷ Allowing health centers to be reimbursed 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 the SDOH needs of their patients.

Dental and Oral Health:

NACHC 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.

²⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9996544/>

²⁷ Medicare Benefits Policy Manual, Chapter 13, Section 70.3.

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 spends over \$1,000 on dental-related procedures,²⁸ 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.

NACHC agrees 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 pleased that CMS is clarifying that these proposals will cover dental and oral health treatments and ancillary services before or during cancer treatment, regardless of primary or metastatic status, site of origin, or initial treatment modality. We further appreciate the clarification that this coverage applies to chemotherapy-related dental services regardless of whether chemotherapy is combined 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.²⁹ These patients should all benefit from covered dental and oral health services.

As with the other services discussed in these comments, it is critical that CMS consider FQHCs’ unique Medicare payment structure for dental services 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 if FQHC billing codes are edited in tandem. We note that the “physicians’ services” component of the Medicare FQHC benefit includes services furnished by dentists. NACHC 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

NACHC recommends CMS adopt a policy that permits providers to collect patient consent for CHI service annually. However, we do not believe patient consent needs to be obtained every time auxiliary personnel provide CHI services. It is important to consider that staff providing these services frequently interact with the patient in person or over the phone, depending on the services. This is similar to current protocols for patients receiving other care management services and ensures patients understand the 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

²⁸ <https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/>

²⁹ <https://www.breastcancer.org/managing-life/immune-system/cancer-treatments/radiation-therapy>

evaluation/management visit with the health center billing practitioner and reconfirmed yearly, either at another in-person visit or virtually.

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

NACHC supports CMS' idea to allow interprofessional consultation to be billed by practitioners authorized by statute for the diagnosis and treatment of mental illness. If implemented, CMS would need to add the CPT codes to an FQHC qualifying visit and the specific providers to the core providers list. These interprofessional consultant codes are already established in Medicare and align with CMS' efforts in the Medicaid space. This past January, a State Health Official (SHO) 23-001 letter³⁰ explained how interprofessional consultative providers in Medicaid can be directly paid, superseding the previous policy where the treating practitioner (for example, an FQHC) was paid an increased rate for a covered Medicaid service. Previously, the treating practitioner 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, the current Medicare regulatory structure does not permit health centers to take advantage of these opportunities like other providers.

We know that CPT codes already allow for 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, NACHC requests for these codes to be added to the FQHC qualifying visit list.**³¹ Furthermore, CMS would need to add 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 under PPS. Allowing more 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 unable 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 an in-person referral or visit, allow for shorter wait times, and support team-based care.³² Utilizing interprofessional consultation is a step towards better utilizing BHI services.

NACHC strongly urges CMS to consider all opportunities to increase reimbursement for behavioral health interventions provided in the primary care setting using a Screening, Brief Intervention and Referral to Treatment (SBIRT) model. To support health centers fully integrating behavioral health into primary care, CMS should consider covering services that provide brief interventions with patients to improve treatment outcomes and prevent the need for more intensive supports. For example, a psychologist may spend significant time helping the patient select treatment facilities or overcome barriers to treatment, such as cost or transportation

³⁰ https://www.medicaid.gov/sites/default/files/2023-01/sho23001_0.pdf

³¹ <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf>

³² <https://www.apaservices.org/practice/reimbursement/health-codes/interprofessional-record-health-consultations#:~:text=Interprofessional%20consultation%20services%20offer%20several.team%2Dbased%20approach%20to%20care.>

to the specific setting.³³ 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 interventions or efforts to connect them to the best treatment. NACHC recommends expanding the coding list to increase the number of ways FQHCs can get reimbursed for SBIRT.

NACHC also supports CMS enhancing flexibilities for medical visits and mental health visits performed on the same day, which could better integrate behavioral health 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 as needing to be a “face-to-face encounter.” For example, a patient could have a qualifying medical visit with a physician, NP, or PA, and then the practitioner 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.³⁴ 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 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.

Request for Information: Definition of “Nurse Practitioner”

NACHC 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 vital roles as part of the care team at health centers.³⁵ NACHC supports the inclusion of the educational requirements in the definition but does not see it necessary to include specific certification requirements. Health centers should be able to hire NPs based on the patient population they serve and their surrounding community’s needs. For example, there are critical roles that a psychiatrist NP or NP addiction specialist holds 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 can develop the skills.³⁶ Additionally, many states have further licensure requirements to ensure patient safety. NACHC supports CMS allowing health centers to hire NPs based on their patient population as well as the NPs’ skills and training 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.³⁷

³³ <https://www.apaservices.org/practice/reimbursement/health-codes/substance-alcohol-abuse-services>

³⁴ <https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-faqs.pdf>

³⁵ <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2022>

³⁶ <https://www.chc1.com/what-we-do/training-the-next-generation/residency-training-programs/> ;

<https://www.unityhealthcare.org/training-education/family-nurse-practitioner-residency>

³⁷ <https://www.aanp.org/advocacy/advocacy-resource/position-statements/nurse-practitioners-in-primary-care#:~:text=Millions%20of%20Americans%20choose%20a>

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 Vacheria Keys, Director of Policy and Regulatory Affairs, at vkeys@nachc.org.

Sincerely,

A handwritten signature in black ink that reads "Joe Dunn". The signature is written in a cursive, flowing style.

Joe Dunn
Senior Vice President, Public Policy and Advocacy