

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1784-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1784-P: CY2024 Physician Fee Schedule Proposed Rules

Dear Administrator Brooks-LaSure,

The National Association of Community Health Workers (NACHW) appreciates the opportunity to comment on the **Proposed Rule [CMS-1784-P] 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 Programs.** Our recommendations address opportunities to acknowledge, advance, and sustain the community health worker (CHW) profession through increased professional recognition and integration of CHW leadership and the capacity of our workforce to improve Medicare services.

Founded in April 2019 as a 501(c)(3) nonprofit, NACHW is the only national membership driven organization that unifies CHWs across geography, race, ethnicity, sector, experience, and identity to support communities to achieve health, equity, and social justice. NACHW is a national voice for CHWs, including Community Health Representatives (CHRs) from tribal nations, Promotoras(es) de Salud, Peers, and hundreds of other workforce titles. NACHW promotes and advocates for the values of CHW self-determination, integrity, and social justice. We facilitate national and state policy discussions, advance CHW professional identity and authentic workforce integration, and amplify CHW leadership and capacity. We have over 2,500 members who represent diverse languages, cultures, geographies and lived experiences. They hail from all 50 states and a growing number of tribes and territories. NACHW's Executive Director is a CHW, Patient Navigator, and survivor of a rare chronic disease. Our organization is governed by a national Board of Directors of predominantly CHWs, Promotoras(es) de Salud, CHRs from tribal nations, and CHW allies. Our board members have decades of research and practice expertise in CHW training and workforce development; community organizing and engagement; intervention design, equity, and social justice advocacy; and policy leadership.

NACHW encourages CMS to integrate CHW roles and services in Medicare. We applaud CMS for including opportunities for community-based organizations (CBOs) that employ CHWs to participate in Medicare through partnerships with billing practitioners. We sincerely appreciate the efforts of CMS to ensure similarities exist between the proposed rule language and some renowned policies and recommendations from the CHW field. For example, thank you for

recognizing the [Community Health Worker Core Consensus Project \(C3\)](#), a project driven by a diverse team of CHWs and CHW allies from across the country that have collaborated for more than 20 years to expand cohesion in the field and to contribute to the visibility and greater understanding of the full potential of CHWs. The C3 Project offers a single set of CHW roles and competencies for reference by those both inside and outside the field as they work to build greater support for and sustainability among CHWs in all settings.

NACHW's comments to CMS are informed by the experiences of our CHW members who are employed across sectors, including state and local public health departments and social services, Federally Qualified Health Centers (FQHCs), schools and other educational settings, faith-based organizations, CBOs, and more. We prioritize the lived experience of CHWs, rather than limiting our focus to "evidence" or "best practices" gathered from research interventions in well-resourced environments.

Our recommendations cover fifteen topic areas. We understand CMS designed CHI services to integrate CHWs specifically. Many of our recommendations list CHI, PIN, and SDOH because we identify important roles for CHWs across each of these services.

1. We note that the proposed rule does not include a definition of "CHW."
 - a. NACHW recommends that CMS adopt the full CHW definition from [American Public Health Association \(APHA\) Policy Number 20091 \(2009\)](#) in the final CHI, PIN, and SDOH rules.
 - b. Additionally, CMS should incorporate the APHA CHW Section policies passed in [2022](#), [2014](#), and [2001](#) in the final CHI, PIN, and SDOH rules.
2. Regarding CHI, PIN, and SDOH service codes and descriptors: In general, we recommend CMS include the full range of CHW core roles as identified by C3 across the socio-ecological model within the suite of CHI, PIN, and SDOH codes.
 - a. CMS should integrate CHWs in Medicare in a manner that supports CHWs to work at the top of their training and experience and reimburse CHW employers and partners for the full range of CHW core roles according to C3 and [APHA Policy Number 20227 \(2022\)](#). As it is currently written, the proposed rules integrate an imbalanced representation of CHW core roles in CHI services. If the final rules over-integrate one CHW core role in particular, we anticipate this will introduce a disincentive for employers to support CHW employees and partners to enact the other nine CHW core roles. Given the scale of the impact this rule change would have on the CHW workforce, we believe it has the potential to undermine CHWs' valuable contributions to community health and wellbeing. Members of the C3 Project team members crosswalked the proposed CHI service codes with the ten C3 CHW core roles and found opportunities for CMS to integrate a more comprehensive range of CHW core roles in CHI services. Here we provide a summary of their assessment. The C3 Project found:

- i. Good integration of Role 4 (Providing Coaching and Social Support) and Role 6 (Building Individual and Community Capacity).
 - ii. Over-integration of Role 3 (Care Coordination, Case Management, and Social Support).
 - iii. Under-integration of Role 2 (Providing Culturally Appropriate Health Education and Information) and Role 5 (Advocating for Individuals and Communities).
 - iv. Severe under-integration of Role 1 (Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems), Role 7 (Providing Direct Service), Role 8 (Implementing Individual and Community Assessments), and Role 9 (Conducting Outreach).
 - v. No integration of Role 10 (Evaluation and Research).
 - b. CMS should revise the proposed CHI services to include a wider range of CHW core roles and refer to APHA Policy Number 20227 (2022) to integrate CHW core roles across all levels of the socio-ecological model within CHI, including those that address community-level priorities and strengths, promote the health and well-being of individuals and families, prevent multiple forms of violence, and promote health equity across all levels of the socio-ecological model.
3. Regarding “*whether it would be appropriate to specify the number of hours of required training, as well as the training content and who should provide the training:*” Currently, the majority of states where a CHW training and/or certification process exists chose optional certification pathways for state-level recognition. These states either passed legislation that identifies CHWs as workforce and/or have implemented CHW training and/or certification guidelines as a way to identify CHWs whose services can be reimbursed by Medicaid. Therefore, NACHW recommends the following:
 - a. For states that have a CHW certification program and/or state recognized CHW training requirements: CMS should allow states to specify who should provide the training and the number of hours required.
 - b. For states that do not have a CHW certification program or state-recognized CHW training requirements: CMS should specify that training content/requirements should align with the C3 Project competencies and APHA Policy Number 20227 (2022), but not specify a required number of training hours.
 - c. CMS guidance should reflect [APHA Policy Number 201414 \(2014\)](#), which urges governments and other entities considering creating policies regarding CHW training standards and credentialing to engage in collaborative CHW-led efforts with local CHWs and/or CHW professional groups. If CHWs and other entities partner to pursue policy development regarding training requirements, a working group composed of at least 50% self-identified CHWs should be established.
4. Regarding “*where and how CHI [, PIN, and SDOH] services would be typically provided (e.g., in-person, audio-video, two-way audio):*” CHWs deliver services at the point of need, based on the preferences and accessibility of the participant(s) across a wide range of employment sectors and work settings. They work with individuals and families, cultural,

faith and community groups, and public and private institutions and organizations, at policy levels, and use a holistic approach based on the strengths, priorities, needs, and challenges of the community they serve.

- a. CMS should place as few restrictions as possible on where and how CHI, PIN, and SDOH services can be performed for the purpose of billing to ensure these services sustain a full range of core CHW roles. This should include services CHWs may provide apart from a face-to-face encounter (e.g., translating written materials, information gathering, etc.) and in group and community settings (e.g., health education and coaching, implementing community assessments, etc.).
 - b. CMS should recognize (but not limit) the following as service sites eligible for reimbursement in addition to clinical settings: CBOs, community and home settings, cultural, faith and other public sites such as libraries, universities and community colleges, food pantries, shelters, WIC, SNAP and TANF offices, senior centers and nursing homes, Medicaid enrollment and citizenship support centers, refugee and asylum seeker organizations, youth development sites including gyms, sports complexes, after school sites, and more. Include in-person, audio-video, and two-way audio settings.
5. Regarding participant consent for CHI, PIN, and SDOH services:
- a. CMS should require participant consent for services to fulfill the CHW Code of Ethics (developed by Georgetown University Law Center for the American CHW Association, a predecessor of NACHW), and to address all industry ethical standards to meet or exceed the Office of Minority Health National Culturally and Linguistically Appropriate Services (CLAS) Standards.
 - b. During a public health emergency, pandemic, natural disaster, or a patient crisis, it may not be feasible to obtain consent. CMS should allow novel methods for informed consent and other tools to facilitate beneficiary access to services ([Rothwell et al., 2021](#)).
 - c. NACHW strongly opposes aspects of the proposed rule that could result in beneficiaries receiving medical bills for working toward their health goals with CHWs, including via CHI, PIN, and SDOH services. We understand CMS does not have the statutory authority to waive cost-sharing for Medicare services outright. Therefore, we recommend CMS take steps to ensure beneficiaries cannot receive medical bills for participating in CHI, PIN, and SDOH services, all of which could be rendered by a CHW. For example, CMS might work with the United States Preventive Services Task Force (USPSTF) to classify all CHI, PIN, and SDOH services as “preventive,” given [section 1833\(a\)\(1\) of the Affordable Care Act](#) requires 100 percent payment for the Initial Preventive Physical Examination (IPPE), Annual Wellness Visit (AWV), and for those preventive services recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual.

6. As to “*whether states typically cover services similar to CHI [, PIN, and SDOH] under their Medicaid programs, and whether such coverage would be duplicative of the CHI service codes:*”
 - a. Given the distinct eligibility requirements for Medicare and Medicaid and rules regarding payment for services for dual-eligible beneficiaries, we have not identified duplication of services between Medicaid and the proposed CHI, PIN, and SDOH services. However, if CMS has identified any issues related to duplication of Medicaid and Medicare services that could have implications for states where CHW-Medicaid integration efforts are already underway, CMS should issue guidance as appropriate to avoid disruption of services to beneficiaries.
 - b. NACHW supports alignment between CHW services covered by Medicare and Medicaid. CMS should conduct a comprehensive assessment/review of CHW integration in Medicaid programs across the US and crosswalk covered Medicaid services with CHI, PIN, and SDOH services. Given Medicare can have the impact of setting the floor for minimum covered benefits for Medicaid programs, CMS should consider lessons learned from Medicaid-CHW integration efforts and consider opportunities to align and build out a comprehensive range of CHW services that accounts for all CHW core roles as described by C3 and APHA Policy Number 20227 (2022).
7. Regarding “*whether there are other service elements not included in the proposed CHI [and PIN and SDOH] service codes that should be included or are important in addressing unmet SDOH need(s) that affect the diagnosis or treatment of medical problems, where CMS should consider coding and payment in the future:*”
 - a. CMS should provide the opportunity for CHWs and allies to inform regular updates (preferably annual) to the CHI, PIN, and SDOH codes to allow for additional services to be incorporated as needed. CHI, PIN, and SDOH codes must include time for trust and relationship-building between CHWs and participants. CHWs regularly address SDOH in addition to the proposed CHI, PIN, and SDOH services (e.g., cultural mediation, group education and training, transportation, medical and community interpretation, addressing trauma and offering emotional support, screening, and referrals). CHWs also play an important role in supporting community response, recovery and resilience to public health emergencies and natural disasters. Additional CHW codes and services should be developed and endorsed by the CHW profession through national CHW leadership engagement, requests for information and other data gathering measures.
 - b. If the aforementioned services are already listed in existing billing codes, CMS should provide references to other covered services CHWs may be qualified to render within the CHI section.
8. Regarding the proposed 1.5 hour/month cap on CHI services, we strongly oppose a frequency limit for CHI, PIN, and SDOH services, including a cap for the 30-minute add-on code. To ensure Medicare equitably reimburses for CHW services and to improve health outcomes at a population level, CMS should not limit the number of hours that may be

billed per month per beneficiary. CHWs initiate, build, and maintain relationships with individuals and groups over time to support them with their health-related goals. The full breadth of CHW core roles and services that influence changes among individuals and communities are likely to exceed 1.5 hours per beneficiary per month. [Rhode Island](#) is one example of a state that opted not to impose billing limits as part of their state plan amendment.

9. Regarding SDOH risk assessments:

- a. CMS should allow reimbursement for CHWs to conduct SDOH risk assessment screenings, as this is already an industry innovation within nationally recognized health plans ([Institute for Medicaid Innovation, 2022](#)). We strongly oppose CMS' proposal to exclude CHWs from reimbursement opportunities for conducting SDOH risk assessments. While many physicians and other primary care providers are certainly capable of conducting SDOH risk assessments, this responsibility should not fall solely on primary care providers. Fortunately, CHWs are well-equipped to conduct SDOH risk assessments for a host of reasons, including their requisite qualities and lived experience, trust and connection with beneficiaries, greater flexibility in their schedule and ability to spend the necessary time with beneficiaries to understand their risk factors, core competency training that is largely focused on assessing and addressing SDOH, and knowledge and connection to community referrals to actually address the SDOH that has been identified.
- b. It is unclear to us whether CMS plans to require primary care providers to provide a medical diagnosis in addition to SDOH risk assessment as part of requirements for reimbursement of CHI, PIN, and SDOH services. Whereas medical diagnoses are central to visits with a physician or other licensed health care provider, SDOH risk assessments can be conducted in many settings. CMS should allow reimbursement for a variety of care team members and service provider types, including CHWs, to collaboratively assess and address SDOH inside and outside of the clinic over the longterm, if necessary. We recommend that CMS decouple medical diagnoses from CHI, PIN, and SDOH services requirements and allow the medical diagnosis and SDOH risk assessment processes to take place independently, but still in collaboration between licensed medical providers, additional care team members, and community partners.
- c. We are not aware if CMS plans to require the use of a specific SDOH risk assessment tool for reimbursement of CHI, PIN, and SDOH services. It is critical that billing practitioners and their partners use SDOH risk assessment tools that identify participant SDOH risks effectively. If required for reimbursement, SDOH risk assessment tools can impact team members' ability to offer beneficiaries the appropriate services. We recommend CMS issue guidance to support CHI, PIN, and SDOH service providers and partners to select quality SDOH risk assessment tools that are designed to be administered and followed up on by a variety of members of multi-disciplinary teams, including those already approved and in use by Medicaid programs.

10. Regarding reimbursement rates, CHWs are a unique workforce, and the financial factors that contribute to CHW sustainment may not be fully understood by all CHW employers. Depending on how the rules for CHI, PIN, and SDOH services are structured, the Medicare program could play an active role in reversing a quickly growing employment culture where some CHW core roles may be considered more important, valuable, or legitimate than others. To address SDOH and improve population health outcomes, we need a national workforce of CHWs whose employers and partners support them to work at the top of their experience and training. CMS should take steps to ensure the Medicare program addresses and anticipates structural inequities that may position CHWs as a precarious workforce. For example:
- a. CMS should authorize reimbursement rates that are sufficient to cover the actual costs of CHW service provision to CHW employers and partners. We recommend that CMS revise the proposed CHI, PIN, and SDOH rates through focused engagement with CHW professional membership organizations and constituencies to better understand and integrate the following considerations when setting reimbursement rates for CHI, PIN, and SDOH services rendered by CHWs. Reimbursement rates for CHW services should be set at levels that:
 - i. Support employers to retain CHW employees and partners on a long-term basis, offer comprehensive benefits, and pay thriving wages that are commensurate with the value of CHWs' lived and professional experience.
 - ii. Equip employers and partners with the funding necessary to support CHW employees and partners to enact a full range of CHW core roles, including those that may not be directly reimbursable/associated with billing codes.
 - iii. Equip employers and partners with the funding necessary to co-create and maintain infrastructure for an employment/partnership environment that enables and sustains CHW service provision, including:
 1. CHW salaries and benefits
 2. Administrative overhead
 3. Program costs, including:
 - a. Equipment required to perform CHW basic job duties (e.g., cell phones, laptops, mileage reimbursement, public health prevention tools, health education and services information, access to EHR and other data collection and management systems)
 - b. Program-specific cross-sectoral partnerships and collaboration
 - c. Supplies for program participants (e.g., short-term resources such as bus tickets, medical motel and shelter vouchers, etc.)
 4. Workforce development costs, including core competency CHW training, certification expenses, and professional development and career advancement opportunities.
 5. Supervision for CHWs, which may involve multiple personnel with unique skills, roles, and credentials such as:

- a. Clinical supervision to oversee related services and the overall care plan.
 - b. Administrative and technical supervision for the purposes of billing, data entry and reporting.
 - c. Program/departmental supervision.
 - d. Reflective, trauma-informed CHW practice supervision with an experienced professional who possesses lived and professional experience as or related to a CHW.
 6. Evaluation and research activities and/or requirements
 7. Initiating, building, and maintaining broader multi-sector partnerships and contracts, referral networks, and community relationships and trust.
11. Regarding “*Whether CMS should require as a condition of payment for SDOH risk assessment that the billing practitioner also have the capacity to furnish CHI, PIN, or other care management services, or have partnerships with community-based organizations (CBO) to address identified SDOH needs:*” We strongly support an upstream approach to encouraging partnerships between billing practitioners and CBOs. CHWs are employed in and work across a variety of sectors, each with its unique strengths, challenges, barriers, priorities, and responsibilities. This sectoral diversity is foundational to the fidelity of the CHW profession, as is diversity in terms of race, ethnicity, geography, gender, language, identity, and lived experience. It is critical that the Medicare program contributes to racial and health equity and the preservation and promotion of a diverse CHW workforce representative of the U.S. population. As it is currently written, the proposed rule has the potential to have unintended negative impacts on the sectoral diversity of the CHW workforce in particular, which in turn, could also influence the aforementioned aspects of CHW workforce diversity. For example, the rule change could compound barriers to sustainable funding experienced by the sectors that employ the majority of the CHW workforce at present, including CBOs. It could also encourage disproportionately high CHW employment growth in the sectors that currently have the fewest barriers to participation in Medicare and other sources of sustainable financing, including health care payer and/or provider organizations and academic institutions. Both potential impacts carry substantial risk to the fidelity of the CHW profession.
 - a. To effectively address SDOH and integrate and sustain CHW services in the Medicare program, CMS must prioritize the following desired outcomes:
 - i. Eliminate barriers to local CBO participation in reimbursement for CHI, PIN, and SDOH services with collaborative methods that preserve CBO strengths and are not administratively/financially burdensome.
 - ii. Incentivize multi-sector collaboration through continuous and sufficient funding for the labor and resources required to cultivate these valuable community-clinical partnerships.
 - iii. Preserve CHW workforce diversity by encouraging growth in CHW employment across sectors.

- iv. Pursue health and racial equity through equitable distribution and re-distribution of funding and resources to communities impacted by inequities, including via local culturally specific CBOs that employ CHWs.
 - b. We recommend CMS authorize a tiered reimbursement structure with a variety of payment levels that are proportionate to the actual costs involved in the provision of CHW services for employers and partners in relation to their chosen approach to CHW integration. For example, when services are rendered by a CHW employed by a local culturally specific CBO in partnership with a billing practitioner, reimbursement rates need to be higher than they would be in the absence of such a partnership to cover the costs associated with partnership and collaboration.
- 12. Regarding CHI requirements, clinical integration, access to the electronic health record (EHR), and liability insurance for CBOs working in partnership with billing practitioners:
 - a. CMS should issue comprehensive guidance to CHW employers and partners regarding clinical integration requirements for CHI services.
 - b. To ensure equitable access to CBO participation in Medicare, CMS should allow billing practitioners to grant non-billing/CBO subcontractors view and edit access to the billing practitioner's EHR so CHWs employed by partner CBOs can access the information necessary to participate in care plans, document the services they provide, and fulfill requirements related to billing. Or CMS should issue guidance that specifies an alternative method by which CHWs employed by a non-billing entity (such as a CBO) can meet documentation requirements for billing.
 - c. CMS should require billing practitioners to ensure non-billing subcontractors, including CBOs, are covered by the billing practitioner's liability insurance.
- 13. Regarding "incident to" billing:
 - a. CMS should publish guidance to billing practitioners and CBO partners as to how to successfully bill for CHI, PIN, and SDOH services rendered by a CHW across settings and partnerships.
 - b. CMS should consider whether any additional billing mechanisms such as standing orders may be better suited to the day-to-day realities of the CHW workforce and if there are any alternative mechanisms that would streamline the process and make it more accessible to a variety of CHW employers.
 - c. CMS should ensure the availability of technical assistance to billing practitioners and non-billing partners/CBOs on how to successfully bill for CHI, PIN, and SDOH services.
 - d. CMS should track and monitor the number of CHI, PIN, and SDOH claims for services rendered by CHWs employed by non-billing partners/CBOs and continuously address barriers and improve access to participation among CHW employers with higher rates of denied claims.
 - e. Given the potential for unique and national implications of the potential integration of CHWs into CHI, PIN, and SDOH services, CMS should promote consistent measurement of community and CHW wellbeing through the use of common process and outcome indicators and constructs developed through a national

CHW-driven national consensus process, including those recommended by the [CHW Common Indicators \(CI\) Project](#). The CI Project's purpose is to contribute to the integrity, sustainability and viability of CHW programs through the collaborative development and adoption of a set of common process and outcome constructs and indicators for CHW practice. The philosophy and methodology underlying the work of the CI Project is popular education. Also referred to as "people's education," popular education creates settings in which people most affected by inequities share what they know, learn from others in their community, and use this to create a more just and equitable society.

14. Regarding CHI initiating visits: To remove barriers for CBOs and expand capacity for services, CMS should allow CHI services to be initiated by CHWs and other non-clinical provider types other than a physician or health care practitioner.
 - a. CHWs are well-equipped to conduct SDOH risk assessments and initiate CHI services in partnership and communication with members of multidisciplinary teams, including primary care providers (PCPs).
 - b. CMS should allow a broader range of qualifying visits/services and provider types beyond Evaluation & Management (E & M) visits and PCPs to initiate CHI services, such as AWW, emergency department (ED) visits, and CBO services. Medicare beneficiaries and additional populations CHWs serve may not yet be engaged with a PCP. Many CHWs are employed by EDs and work with participants to facilitate connections to primary care and other services. The ED is a critical opportunity to connect beneficiaries with ongoing and preventive services.
 - c. CMS should reimburse for all CHI services that occur within 12 months of qualifying visits.
 - d. CMS should issue guidance to specifically clarify or better define "general supervision" as it relates to CHWs and explain what is exactly meant by being under a physician or other practitioner's overall direction.
15. Regarding quality assurance, evaluation, employer accreditation, and CHW program standards: We are aware that the proposed rule could have the impact of encouraging states and/or employers to implement industry standards for CHWs regarding recruitment, hiring, training, management, work practices, coaching, performance assessment, and more.
 - a. While we acknowledge and support the idea of reinforcing basic employer responsibilities, we hold substantial concerns with the potential negative implications that could result from the standardization of CHW work practices and CHW employer/program accreditation at this time.
 - b. If such standards are to be developed, there must be a CHW field-wide collaborative effort initiated and led by CHWs through a careful, national consensus-driven process that would likely take several years or more. These efforts have only recently begun and are currently incomplete. For these and additional reasons, we believe that encouraging states to develop plans to implement CHW employer/program standards would be premature.

- c. At this time, the likelihood of harm to the CHW workforce outweighs potential benefits, with disproportionate and compounding impacts on CHWs employed by local CBOs, where the majority of CHWs work. While we understand that one of the intentions of CHW employer/program accreditation is to protect the integrity of CHWs, we believe that to do so at this time would pose serious risks to the fidelity and self-determination of the CHW workforce.
- d. However, we see tremendous value in CHW-led measurement of the processes and outcomes of CHW programs, including CHW and community experiences and wellbeing across a full range of CHW employment sectors and settings. Fortunately, the development of a set of common process and outcome indicators and constructs has been underway for over a decade, through an evidence-informed, consensus-driven, national process led by CHWs that is funded by the Centers for Disease Control and Prevention (CDC). Wider adoption of these common CHW indicators will promote CHW wellbeing, which is essential to sustain the vital work CHWs do. It will also allow for aggregation of data about CHWs and CHW programs and empower CHW employers and partners with tools they can use to learn about what works and what doesn't work for the CHWs they work with and the communities they serve. Ultimately, wider adoption of common CHW indicators will assure the quality of CHW programs and services, including CHI, PIN, and SDOH, allow for necessary customization based on local and statewide CHW workforce strengths and priorities, and promote a diverse CHW workforce.

Thank you for your consideration of our comments. Please do not hesitate to contact me at dsmith@hria.org.

Sincerely,



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