September 09, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-1807-P; Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments; (August 7, 2023)

Dear Administrator Brooks-LaSure,

The National Association of Community Health Workers (NACHW) thanks the Centers for Medicare & Medicaid Services (CMS) for your pursuit of strategies to realize equitable, accessible, affordable and high-quality health care systems and services for all Medicare beneficiaries.

NACHW thanks CMS for the opportunity to provide comment on the CMS Notice of Proposed Rule Making (NPRM) on the revisions to Medicare payment policies under the Medicare Physician Fee Schedule (PFS) for calendar year (CY) 2025, published in the July 31, 2024, *Federal Register*.

About NACHW

Founded in April 2019 as a 501(c)(3) nonprofit, NACHW is the only national membership driven organization that unifies community health workers (CHWs) across geography, race, ethnicity, sector, experience, and identity to support communities to achieve health, equity, and social justice. NACHW is the national voice for CHWs, including community health representatives (CHRs) from tribal

nations, promotores de salud, and over 95 additional titles within the CHW profession.

Our membership is over 4,000 individuals strong and spans all 50 states and a growing number of tribes and territories. Our executive director is a CHW, a patient navigator, and survivor of a rare chronic disease. Our founders and board of directors are CHWs, promotores de salud, CHRs from tribal nations, aunties and uncles from Native Hawaiian, Pacific Islander and Asian American populations, and cross-sector-CHW allies from all over the country. These individuals lead NACHW with 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 is proud to advocate for all CHWs across sectors, including CHWs employed by community-based organizations (CBOs), state and local public health departments and social services, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), schools and other educational settings, faith-based organizations, healthcare payer and/or provider organizations, and more.

Background

We understand CMS designed Community Health Integration (CHI) services with the intention to appropriately value and reimburse the work of auxiliary personnel, including CHWs specifically (although not exclusively), and we applaud CMS' leadership in the integration of CHWs within Medicare services. In 2023, NACHW submitted comments (gathered from our national CHW and ally membership) to CMS about the proposed CHI, Principal Illness Navigation (PIN), and social determinants of health (SDOH) risk assessment services. Most of our comments and recommendations from 2023 remain relevant and reflect our commitment to promote CHW self-determination, integrity, equity, and social justice.

Our enclosed comments are grounded in the following realities of the CHW profession:

1. CHWs are a predominately female workforce of exceptional diversity, speaking at least twenty-eight different languages.
2. The majority of CHWs are employed by CBOs and public health departments.
3. Nine percent of CHWs who responded to our 2021 national survey (867 responses from 857 zip codes) labor without any compensation at all or receive gift cards or honorariums for their work.
4. Twenty-eight percent of CHWs who responded to our 2021 survey do not feel the compensation provided to them is equitable or that it offers a livable wage.
5. A wage gap exists within the CHW profession. White CHWs receive a higher wage than non-white CHWs and male CHWs receive a higher wage than female CHWs.
6. The National Academies of Sciences, Engineering, and Medicine and the Presidential COVID-19 Health Equity Taskforce have confirmed the need to advance health equity strategies that emphasize recruitment of a workforce that reflects the cultural and linguistic diversity of our nation and the lived experiences of the individuals and communities served.
7. CHWS are a critical workforce to diversify healthcare systems and services and are proven to build trust, deepen cultural alignment and reduce health inequities.

Comprehensive integration of the CHW profession and its identities, roles, and skills into Medicare and Medicaid services by CMS will have a profound impact on the Center's ability to accomplish the five priorities identified in the CMS Framework for Health Equity (CMS, 2022), particularly priorities 2, 3, 4, and 5.

Recommendations

In response to the Request for Information (RFI) within the proposed rule, NACHW offers the enclosed recommendations on seven intersecting topic areas.

We applaud CMS for having developed CHI services specifically with frontline public health workers like CHWs in mind, and we acknowledge that CHI service codes are not designed for use exclusively by CHWs. CHW professional roles and training as defined by the CHW Core Consensus Council (C3, formerly known as the

CHW Core Consensus Project) prepare CHWs to deliver navigation and other services that apply within CHI and PIN services. Additionally, many CHWs also identify as peers. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines peers as persons with lived experience in and recovery from mental health conditions, substance use and abuse disorders and other conditions (SAMHSA, 2017).

Because many CHWs may also have requisite qualities and skills and may identify as navigators and peers, many of our recommendations apply across CHI, PIN, PIN-Peer Services (PIN-PS) services. Our recommendations also have applications for SDOH risk assessment services.

1. **CHW definition and core CHW roles:**

    a. NACHW recommends that CMS adopt in the final rules the full CHW definition from APHA Policy Number 20091, which NACHW endorses: *"A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy,"* (APHA, 2009). We note that the current rule does not include a definition of "community health worker", which has and can cause confusion about the definition of a CHW among employers, policymakers, and additional interested parties.

    b. NACHW encourages CMS to integrate recommendations from APHA Policy Number 20227 (APHA, 2022), APHA Policy Number 201414 (APHA, 2014), and APHA Policy Number 200115 (APHA, 2001) in the final rules to preserve and promote the fidelity of the CHW workforce and our contributions to community health and wellbeing.

c. NACHW recommends that CMS integrate and reimburse CHW employers for the full range of CHW core roles as identified by C3 (Rosenthal et al., 2014-2022 and APHA, 2022) within the suite of CHI, PIN, PIN-PS, and SDOH risk assessment service codes and descriptors in general and across interpersonal, group, family, community, organizational, institutional, and policy levels (see also: "socio ecological model," e.g., McLeroy et al., 1988). This advances Priority 3 within the CMS Framework for Health Equity, which outlines the Center's commitment to "build capacity of health care organizations and the workforce to reduce health and health care disparities," (CMS, 2022).

2. **Related services that may not be described by the current coding:** Regarding the Center's request for "*comment on any related services that may not be described by the current coding that we finalized in the CY 2024 PFS final rule and that are medically reasonable and necessary "for the diagnosis or treatment of illness or injury" under section 1862(a)(1)(A) of the Act. We believe we can work within the current coding framework and explore additional opportunities to create codes that describe reasonable and necessary services furnished by billing practitioners and the auxiliary personnel under their general supervision,*" (page 73 of the proposed rule):

    a. The current rules integrate an imbalanced representation of CHW core roles in CHI and PIN service codes. Because the rules over-integrate CHW Core Role 3 (Care Coordination, Case Management, and Social Support), there exists a disincentive for employers to support CHW employees and partners to enact the other nine CHW core roles. Given the scale of the impact CMS rules will have on employers, state policymakers, and the CHW workforce, the imbalanced representation of CHW core roles in Medicare will limit CHWs' valuable contributions to community health and wellbeing. In turn, this could inadvertently impede implementation of the CMS Framework for Health Equity (CMS, 2022), particularly Priorities 3 and 4.

b. In 2023, members of the C3 Council team compared the 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 Council 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).

c. NACHW recommends that CMS include group classes within CHI, PIN, and PIN-PS. We note that CHI and PIN services do not encompass group-level services or classes. To further advance the Center's priorities related to health equity, and because many CHW core roles are applied at a variety of levels of socio-ecological influence (including individuals, groups, classes, families, organizations, communities, institutions, and at policy levels), NACHW recommends that CMS revise the proposed CHI services to include a wider range of CHW core roles according to recommendations and findings from C3 and APHA Policy Number 20227 (APHA, 2022). NACHW urges CMS to include all CHW core roles, including those that address community-level priorities and strengths, promote the health and wellbeing of individuals, groups, and families, prevent multiple forms of violence, and promote health equity across all levels.

3. **Barriers to furnishing services addressing health-related social needs:** Regarding the interest of CMS in *"feedback regarding any barriers to furnishing the services addressing health-related social needs, and if the service described by the codes we established are allowing practitioners to better address unmet social needs that interfere with the practitioners' ability to diagnose and treat the patient. This could include barriers specific to certain populations, including rural and tribal communities, residents of the U.S. Territories, individuals with disabilities, individuals with limited English proficiency, or other populations who experience specific unmet social needs,"* (pages 73-74 of the proposed rule):

    a. The current rules require the beneficiary to have an initiating visit with a billing practitioner before auxiliary personnel can be reimbursed for CHI, PIN, or PIN-PS services. This means CHWs cannot initiate CHI, PIN, or PIN-PS services, even if they work directly under the supervision of a licensed billing practitioner. Further, this requirement complicates the process for the majority of CHWs who are employed by CBOs, where there isn't a billing practitioner on staff or billing infrastructure. This represents major barriers to implementation of CHI, PIN, and PIN-PS services and to the sustainability of positions and programs that support frontline community-based workers like CHWs, many of whom currently furnish these and a wide range of additional services that address health-related social needs without adequate or sustained funding.

    b. The initiating visit requirement for CHI, PIN, and PIN-PS services is also a major potential barrier to beneficiaries to receive services that address unmet social needs that interfere with the practitioners' ability to diagnose and treat the patient. This requirement may compound existing barriers to individuals who already experience significant obstacles to accessing health care and are among the individuals and communities who may be likely to benefit most from CHI, PIN, and PIN-PS services, including:

i. Individuals who live in rural areas, tribal communities, and island populations due to the need to travel to an initiating visit with a licensed billing practitioner prior to receiving CHI and PIN services, which may address their transportation-related barriers to medical appointments;
ii. Individuals with disabilities due to a variety of reasons, depending on their situation and experiences;
iii. Individuals with limited English proficiency due to lack of consistent language access services and additional experiences related to language barriers and lack of cultural humility within systems of health care and additional services;
iv. Individuals experiencing unstable housing or house/homelessness due to experiences of stigmatization and marginalization by health care and other service systems;
v. Persons who are returning from incarceration due to interruptions in benefits and additional experiences of barriers to care related to housing, income, transportation, and marginalization;
vi. Historically oppressed peoples and other individuals experiencing inequities due to experiences of multiple forms of violence against them within health care and other service systems throughout history and the present.

c. The CHI initiating visit requirement in the current rule presents barriers to rendering CHI, PIN, and PIN-PS services for CHWs and additional community-based workers. CHWs specifically are highly qualified to meet participants where they are; we work with individuals and communities to address barriers to their health goals. Often, this involves working with individuals to establish a trusting relationship with a primary care provider/medical home. Without the support of a CHW or additional community-based workers, many individuals from the above populations might not access primary care in the first place, and therefore wouldn't be able to access CHI, PIN, or PIN-PS services. CMS should leverage CHI, PIN, and PIN-PS services to value and compensate CHWs and additional community-based workers. Our

labor connects individuals and communities who experience multiple barriers to care with a primary care provider and additional vital services, and we serve critical roles within multidisciplinary teams that effectively maintain and deepen those connection.

d. The current rule requires SDOH risk assessments to be part of a visit with a licensed billing practitioner, which means CHWs, and additional auxiliary personnel cannot bill for SDOH risk assessments. While billing practitioners can certainly build positive relationships with their patients, CHWs specifically focus on building trust and relationships with people and communities who have been harmed by health and other systems throughout history and today. CHWs are often successful at building trust *because* they are not medical providers, and because they have lived experience, language, culture, geographic location, and additional qualities in common with the community served. Together, CHW qualities *and* skills comprise our unique core CHW competencies. These competencies are unduplicated by other clinical staff and auxiliary personnel. "*Qualities, such as connection to the community served, help to facilitate the trust and relationships CHWs need to be effective in their work with the individuals, families, and communities they serve. This aspect of CHWs has long been valued and stands the test of time,"* (C3, 2018).

4. **Alternative payment models (e.g., Advanced Primary Care Management (APCM) Benefit):** To address the aforementioned barriers, NACHW encourages CMS to expand options for CHWs and additional qualified auxiliary personnel to receive payment for SDOH risk assessments, as well as to initiate CHI services.

   a. For example, CMS might require, as a condition of payment, evidence that CHI services are furnished by a CHW or auxiliary personnel *in collaboration or partnership with* (versus "under the supervision of") the participant's primary care provider within a specified timeframe (e.g., 12 months) of a face-to-face or virtual visit with the primary care provider.

b. We realize that the above recommendations may not be consistent with the Center's application of the "incident to" regulations as a condition of payment for CHI, PIN, and PIN-PS services. While we recognize the technical pathway for reimbursement of some services furnished by CHWs via the Center's application of "incident to" regulations, we have not seen evidence that these regulations adequately reflect the realities of day-to-day circumstances for CHWs and the individuals and communities we serve. In light of this, NACHW encourages CMS to further develop alternative payment methodologies that facilitate authentic integration of CHWs and additional auxiliary personnel on multidisciplinary teams, including through incentivizing partnerships and contracts between health care provider organizations and community-based CHW employers.

c. Additionally, NACHW recommends that CMS allow multiple providers to bill for CHI, PIN, and SDOH risk assessments, given the reality that no one organization offers all the services necessary to care for the whole person. It is often, if not always, the case that services outside of the primary care provider's office are necessary to accomplish the participant's care plan and address their health-related social needs and goals.

5. Nuances or considerations related to training and certification requirements:

Regarding "*We are also interested in whether there are nuances or considerations that CMS should understand related to auxiliary personnel and training, certifications or licensure barriers or requirements that are specifically experienced by practitioners serving underserved communities. This could include settings such as community mental health centers, community health clinics including FQHCs and RHCs, tribal health centers, migrant farmworker clinics, or facilities located in and serving rural and geographically isolated communities including the U.S. Territories,*" (page 74 of the proposed rule):

a. Lived experience that is shared or in common with the community served is a requisite CHW quality. While NACHW respects the autonomy of the CHW workforce to develop (or not develop) CHW certification in their state, we also recognize a myriad of pros and cons to CHW certification. On the one hand, CHW certification can promote national professional identity and CHW career lattices. On the other hand, state-level certification processes, including background checks, can present major barriers to entry to employment for some CHWs who may be hesitant to pursue certification precisely because of their lived experiences. CHW certification processes must be sensitive to and accommodate this reality and should offer the necessary support for qualified CHWs to complete the certification process if desired.

b. We are pleased to see that CMS recognized the C3 CHW core competencies in the current rule. We recommend CMS issue guidance to clarify and raise awareness of the CHW training requirements in the current rule.

6. CBOs and their collaborative relationships with billing practitioners:

a. NACHW recommends that CMS issue comprehensive guidance to CHW employers and partners regarding clinical integration requirements for CHI services, including guidance to billing practitioners and CBO partners as to how to successfully bill for CHI, PIN, PIN-PS, and SDOH risk assessment services rendered by a CHW across settings and partnerships.

b. To ensure equitable access to CBO participation in Medicare, NACHW recommends that CMS 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 rendered, 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. NACHW recommends that CMS require billing practitioners to facilitate liability insurance coverage for CBOs and other partner organizations that employ CHWs or additional auxiliary personnel who render CHI, PIN, or PIN-PS services.

d. NACHW recommends that CMS ensure the accessibility of technical assistance for billing practitioners and CBOs and other partner organizations that employ CHWs or additional auxiliary personnel on how to successfully bill for CHI, PIN, and SDOH services.

7. Evaluation

a. NACHW recommends that CMS track and monitor the number of CHI, PIN, and SDOH claims for services rendered by CHWs employed by CBOs and partner with local *CHW networks* (CBOs, including CHW associations and coalitions, with leadership and/or membership that is comprised of 50% or more of CHWs, and whose mission and activities focus on workforce development, mentoring, member mobilization, and advocacy) to continuously address barriers and improve access to participation across a full range of CHW employment sectors.

b. NACHW recommends that CMS promote consistent measurement of community and CHW wellbeing through the use of common process and outcome indicators and constructs developed through a CHW-driven national consensus process, including those recommended by the CHW Center for Research and Evaluation (CHW CRE, formerly known as the CHW Common Indicators Project). The CHW CRE'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.

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

Sincerely,

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