



September 11, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

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

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure,

National Patient Advocate Foundation (NPAF) is pleased to submit comments on this proposed rule as it relates directly to the navigation work we do and the people we serve. We especially appreciate the rule's acknowledgment of the need to expand beyond current management services focused heavily on clinical aspects of care rather than social aspects as that broader focus is exactly ours. Our overall suggestion is to further expand this intervention to include assessment of financial needs and referral to appropriate public and private safety net programs and community resources.

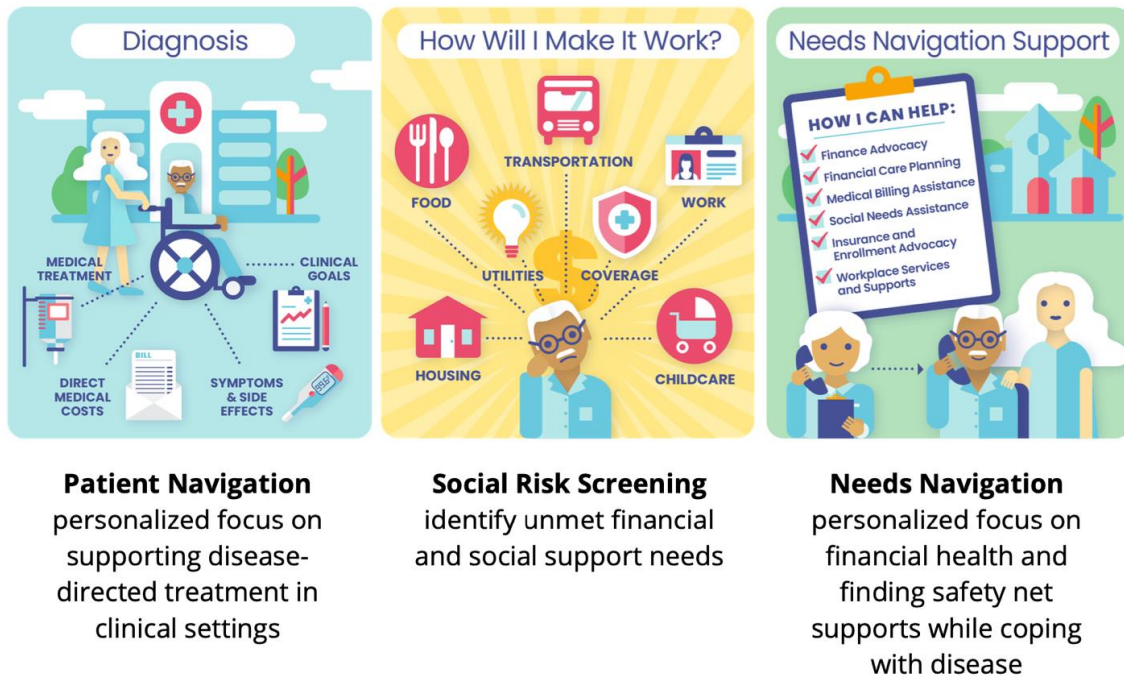
Our direct patient services counterpart, Patient Advocate Foundation (PAF), has delivered skilled needs navigation services specifically supporting social and financial well-being for thousands of limited-resourced patients and families over its 26 years. Needs navigation, detailed in [this NPAF 2022 issue brief](#), is an effective intervention that responds to what patients and families report as their most pressing concerns that interfere with healthcare access and affordability.

Because of the proposed rule's inclusion of navigation services, we want to point out that Needs Navigation is an innovative intervention to address patients' top of mind financial and social concerns in the context of coping with their illness. Similar to what is outlined in this proposed rule, [these services](#) are provided by people skilled in person-centered communication and resources coordination who serve as a key contact in helping find and access safety net support for patients and families experiencing financial hardship and/or social burdens because of their medical conditions. Needs navigation services have evolved over the past two and a half decades as a critical component of person-centered care to

address those patients’ needs necessary for making ends meet and maintaining their financial health while coping with disease. These services now should be expanded and integrated with the healthcare ecosystem to provide real-time relief and practical help for limited-resourced patients and families confronted with medical debt, household financial hardships, or other financial and social strains that contribute to poorer health outcomes.

As noted in the proposed rule, while some elements of needs navigation services may be provided by a variety of professionals and laypersons such as community health workers, social workers, financial advocates, patient navigators, patient advocates and others in various hospital and clinical settings, these different roles and the variability in services availability, comprehensiveness and quality among them are confusing to people and health care providers, imposing barriers that interfere with equitable access to the benefits of what needs navigation services can achieve. Unifying the field around consistent definitions, domains of support, and core competencies is a vital next step and this proposed rule is a step in that direction. In addition, describing needs navigation and quality accountability with clear, resonant, and consumer-tested terms presents a key opportunity to expand availability and address enduring health inequities. The figure below shows how needs navigation could be integrated into existing health care:

Continuity of Care from Clinic to Community



We offer ourselves as a partner in CMS’ effort to expand access to navigation services as PAF has developed specialized needs navigation expertise over its 27 years providing telephonic financial and social services to patients nationwide with limited resources and health care access challenges. In [2021 alone](#), PAF delivered comprehensive needs navigation to 20,374 people from all 50 states and

Washington, D.C. Forty-six percent (46%) of these patients reported an annual household income under \$24,000.

With this perspective, we appreciate the opportunity to make the following comments:

Proposed Principal Illness Navigation (PIN) Service Definition

We are needless to say very pleased to see confirmation of the importance of navigation services by the inclusion in the proposed rule of payment for such services. We support these aspects of the proposed rule with additional recommendations:

- That SDOH for PIN means economic *and* social condition(s) that influence the health of people and communities and the proposal to adopt CPT's examples of SDOH, with additional examples. While we agree with the proposal that SDOH(s) may include but are not limited to food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities, we recommend that SDOH assessment for PIN also include assessment of the patient's overall financial needs and concerns and that navigators have training in this specific area.

Finances were an issue for patients as the majority of over 2,800 patients surveyed by PAF in internal research done in 2019 (63 percent) reported financial distress as a top concern surpassing even the possibility of dying. Household material hardships such as food, energy and housing insecurity are frequent sources of concern contributing to dire circumstances and disparate health outcomes among people coping with complex chronic conditions. NPAF therefore advocates for needs navigation, which helps overcome health system shortfalls by identifying and striving to address, the constellation of patients' unmet social and financial needs. These are particularly prevalent in underserved populations and limited resourced communities. PAF's 2021 program evaluation data show that after navigation was provided, 77 percent of patients reported reduced distress and 100 percent reported a better understanding about health care costs and awareness of community resources that can help them.

- That, as proposed, all auxiliary personnel who provide PIN services be certified or trained to provide all included PIN service elements including financial assessment and referral to appropriate public and private safety net programs and community resources and be authorized to perform them under applicable State law and regulations. We are very aware of the need for such training and certification and also that obtaining it can be a financial obstacle for candidates from under-resourced communities and so encourage CMS to address this equity issue going forward.
- That, as proposed, PIN services should be furnished following an initiating E/M visit addressing a serious high-risk condition/illness/disease that requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.

Proposal to establish a stand-alone Social Determinants of Health (SDOH) G code and include it as optional element in Annual Wellness Visit

We support this new G code and would just note that current CMS SDOH assessments do not include assessing financial needs. As noted earlier in this letter, that needs to be included as this area is of key importance to patients and their families.

While typical social risk assessment may get at some of this financial need information, our experience is that people do not necessarily volunteer their financial concerns without prompting, yet are grateful when someone asks about them and then helps address them. Our PAF navigators and organization have over two decades of experience in this area and we are available to assist with supplying proven financial assessment tools and experience for this important area. CMS should think of financial needs assessment and navigation help on par with assessing social needs as our experience, and research, confirm they are among the most important considerations people have about their health care.

We also agree that patient consent needs to be obtained for any SDOH assessment done outside of an AWV, when patient cost-sharing is involved. It is unfortunate that CMS lacks the statutory authority to waive such cost-sharing and we will continue to advocate for such authority when working with Congress.

Conclusion

NPAF greatly appreciates CMS' intent to include PIN services in this proposed rule and believe that by expanding them to include financial assessment and referral to appropriate services they will indeed improve beneficiaries' care. Ultimately, we hope that this effort will expand access to needed community services so that any referrals can actually be fulfilled and identified needs met. Providing needs navigation services directly to patients and caregivers is a hallmark of PAF's two and a half decades of organizational experience, expertise, and history. We are happy to share lessons learned and welcome the opportunity to meet directly with Administration staff to discuss these comments and opportunities to scale needs navigation as part of efforts to achieve equitable and affordable healthcare reform.

Please contact me at Rebecca.kirch@npaf.org if NPAF can provide further details.

Respectfully submitted,



Rebecca A. Kirch

Executive Vice President, Policy and Programs