OCHIN

A driving force for health equity

Submitted via regulations.gov

September 11, 2023

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

Re: *Cost Year 2024 Payment Policies under the Physician Fee Schedule*

Dear Administrator Brooks-LaSure,

On behalf of OCHIN, we appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Proposed Cost Year 2024 Payment Policies under the Physician Fee Schedule. OCHIN is a national, nonprofit community-based health IT innovation and research network that includes nearly 2,000 community health care sites with 30,000 providers in 39 states, reaching more than 5.5 million patients. This proposed rule represents a watershed moment in advancing equity through Medicare payment policy. OCHIN is deeply appreciative of the numerous steps forward in the proposed rule to greater access to care for the most underserved and rural communities around the nation. These policies are critical prerequisites to building capacity and infrastructure to move to sustainable value-based delivery and payment models.

Since its inception over 20 years ago, OCHIN has focused on expanding access to underserved communities to quality health care services. Today, the OCHIN network includes 137 federally qualified health centers (FQHCs) as well as FQHC look-alikes and other community-based clinics such Ryan White HIV/AIDs centers, local public health agencies, corrections, school-based mental health programs, youth authorities, and rural clinics. Among OCHIN's network members' patients are 57% women, 7% Asian, 19% Black, and 36% Hispanic/Latinx. In addition, 3 out of 5 have chronic conditions, 1 out of 3 are best served in a language other than English, approximately half have Medicaid coverage, and another quarter are uninsured. OCHIN has significant technical expertise and practical experience implementing HRSN screening and evaluation, data collection, and navigation in community settings that have faced persistent underinvestment and under-reimbursement due to payment systems that do not account for the higher clinical patient complexity and the structural inequality faced by members' patients that impede improved health outcomes.

OCHIN specifically applauds provisions of the proposed rule that advance equitable access to care by providing foundational payment policies that enable providers to address-health related social needs (HRSN). We also strongly support dismantling inequitable barriers that patients receiving care from federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs) have faced because of restrictive telehealth and remote physiological and remote therapeutic management coverage and payment policies that CMS proposes to lift. This proposed rule represents significant changes in coverage and payment policies that OCHIN strongly supports but we do urge CMS to consider some modifications

as detailed below to place FQHCs and RHCs in the same position to meet their patients' needs as other community providers when providing HRSN services and care leveraging digital health modalities.

The following are broad areas that OCHIN would like to highlight, and additional specific comments are contained in the Appendix.

Addressing Health Related Social Needs

OCHIN supports the all of the proposed policies that address social drivers of health (referred to primarily in the proposed rule and the Appendix as Health-Related Social Needs (HRSN)) with a few recommended modifications. OCHIN has been advocating for many of these changes for years and there is a substantial evidence base that OCHIN researchers have contributed to underscoring the importance of addressing HRSN. We enthusiastically support the addition of the Community Connection HRSN quality measure as part of the Merit Incentive Payment System (MIPS) program.

However, we strongly urge CMS to complete the needed full continuum of measures and add the "Resolution of At Least 1 Health-Related HRSN measure" to the MIPS specialty measures sets that was recommended through the Measure Applications Partnership. We also urge CMS to ensure that the payment for screening required domains aligns with the quality measures that are already adopted into several Medicare payment programs. Specifically, we urge CMS to include intimate partner violence in the screening domains.

Expanding Access to Digital Health Modalities

OCHIN similarly strongly supports a range of digital health provisions in the proposed rule with particular enthusiasm for 1) the addition of HRSN screening as a covered telehealth service and 2) the CMS proposal that would enable Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to bill separately from the all-inclusive rate for remote physiological management services (RPM) and remote therapeutic management services (RTM). OCHIN researchers have submitted for publication two studies that show that patients who received majority telehealth during the pandemic did just as well as those who received majority in-person care in terms of chronic disease management.

We do urge CMS to clarify that RHCs and FQHCs can bill the new code (G0511) multiple times for the same patient in a month to enable clinicians to use necessary (and non-overlapping) care management services as this particular code includes chronic care management, behavioral health integration (BHI), principal care management (PCM), chronic pain management (CPM), and it continues to grow as items like community health integration are added. If finalized as is, FQHCs and RHCs will have to decide whether or not to screen for HRSN or provide patients much needed RPM/RTM services. This creates structural inequality in the payment program.

Further, the reimbursement amount--$72—is inadequate, particularly as compared to other providers that will receive $118.27 in the first month and $98.95 in the following months. We urge CMS to modify reimbursement for these sites of service to match the national average payment rates for comparable RPM services under the Physician Fee Schedule, which better reflects the cost and complexity of delivering RPM/RTM services.

Conclusion

OCHIN is able to provide rapid, data-driven feedback that would support the agency's assessment of how policy proposals would impact community-based providers, despite significant structural inequality and resource limitations. Please contact me at stollJ@ochin.org.

Sincerely,

Jennifer Stoll
Executive Vice President
External Affairs

APPENDIX I

The following proposed policies will significantly expand access to care for patients who are currently underserved and in rural communities as well as support the sustainability of their providers.

Addressing health related social needs (HRSN) is an essential step to re-engineering Medicare payment systems to better reflect the needs of Medicare beneficiaries in underserved communities and their providers. Structural inequality cannot be overcome without fundamentally changing status quo approaches to Medicare payment, including quality measure development, validation, and adoption where processes and systems consistently ignore underserved communities and do not reflect processes and outcomes that are core to providing quality care—identifying and addressing social risk factors and taking steps to achieving whole person care.

The following are key factors that we urge CMS to consider as you consider OCHIN's recommendations:

- Notably, over 2 million individual patient screenings for HRSN have been documented in OCHIN's instance of the Epic EHR by network members since 2016 and 30,000 are added monthly, which has produced the nation's largest EHR-embedded dataset on HRSN in primary care community clinics and allows providers and researchers to empirically assess how HRSN affect patient and population health.
- OCHIN facilitates quality measure reporting for our members through technical, workflow, and clinical support for a wide- range of quality measures including MIPs, the Heath Resources and Services Administration's (HRSA) Uniform Data Systems (UDS), and state and payer specific quality measures.
- Our 40 researchers specialize in health disparities and include some of nation's preeminent HRSN subject matter experts and a number of OCHIN investigators are members of the SIREN Network Research Advisory Committee and one investigator is a co-author of the groundbreaking 2019 National Academies report on integrating social care into health care settings.
- OCHIN has implemented and evaluated a variety of HRSN data collection tools, including the CMS Accountable Healthcare Communities tool and PRAPARE, across clinical settings and developed enhanced EHR-based SDOH collection/presentation tools for primary care providers.
- OCHIN has undertaken implementation science trial of approaches needed to advance community health clinics collecting and responding to patient-reported HRSN needs and conducted comparisons of methods for enhancing uptake of HRSN screening in community health clinics.
- Examples of our HRSN research include assessment of the association between patients' HRSN status, diabetes control, and the impact of social service referral-making on both HRSN and diabetes outcomes.
- OCHIN technical experts have played a central role in the development of national HRSN domains and data element standards through the HL 7 Gravity Project.
- OCHIN's CEO has served on the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology (ONC) federal Health Information Technology Advisory Committee (HITAC) and strongly supported adoption of the HRSN domains and elements in version 2 of the US Core Data for Interoperability (USCDI).
- OCHIN is also undertaking accelerated technical testing of the USCDI HRSN adopted data elements and domains to advance cross-sector interoperability to support close looped digital referrals.

We are particularly pleased to lend our support to the following proposals:

- Addition of the health-related social needs (HRSN) "community connection" quality measure to Merit Incentive Payment System (MIPS) program as a voluntary measure and aligned with the HRSN screening measure that CMS included in MIPs for fiscal year 2023.
- New HSRN screening code and reimbursement (addition of Healthcare Common Procedure Coding System (HCPCS) code GXXX5 (administration of a standardized, evidence based SDOH assessment tool, 5-15 minutes) on a permanent basis in conjunction with an evaluation and management (E/M) visit.
- Addition of an optional HRSN screening to the Annual Wellness Visit (AWV).
- Authorization to conduct HRSN screening as a telehealth covered service on a permanent basis.
- Creation of additional G-codes for services addressing HRSN, including codes to
    - provide Community Health Integration (CHI) services which enable payment for social workers, Community Health Workers (CHWs), and other staff who furnish CHI services that address HRSN identified during an E/M visit or AWV.
    - Provide coverage for Principal Illness Navigation (PIN) Services.
- Extension of COVID-19 public health emergency (PHE) telehealth flexibilities through December 31, 2024, including flexibilities for FQHCs and RHCs.
- Authorization to utilize real-time audio and video interactive communications for direct supervision through December 31, 2024, and we urge permanent extension.
- Separate payment for remote physiological management (RPM) services in RHCs and FQHCs, but we seek additional clarification with regard to incident to and urge CMS to place RHCs and FQHCs on equal footing to other providers on the PFS.
- Extension of current flexibilities for periodic Opioid Treatment Program assessments that are furnished via audio-only telecommunications through the end of CY 2024
- For FQHCs and RHCs:
    - Authorization that addiction counselors who meet all of the requirements of Mental Health Counselors (MHCs) may enroll with Medicare as MHCs.
    - Change the required level of supervision for behavioral health services furnished "incident to" a physician or NPP's services in RHCs and FQHCs to allow general supervision, rather than direct supervision, consistent with the policies finalized under the PFS during last year's rulemaking for other settings.
    - Continued authorization of direct supervision via audio/video technology at RHCs and FQHCs.
    - Clarification that the sequencing and mode of consent can take various forms and direct supervision is not needed for beneficiary consent for Chronic Care Management and virtual communications services.

PROPOSALS OCHIN URGES MODIFICATION

While CMS has outlined significant steps to advance equitable access to care, OCHIN urges CMS to remove the following impediments to quality care and improved outcomes, particularly for patients receiving care from FQHCs and RHCs.

- Modification of the HRSN Risk Assessment Required Components. CMS provides that required elements of the screening would include an "SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties." While CMS states that "billing practitioners may choose to assess for additional domains beyond those listed above if there are other prevalent or culturally salient social determinants in the community being treated by the practitioner," we urge inclusion of

interpersonal safety (IPS) in the required determinants of health domains given the strong evidence base CMS has provided for doing so and to ensure alignment with the domains that have been implemented in screening measures for a new of Medicare including MIPS.

- HRSN Resolution Measure. We urge CMS to also add the "Resolution of At Least 1" HRSN quality measure. This Resolution measure would establish clinical continuity and form a complete HRSN measure set as established by the Accountable Health Communities (AHC) model and supported by the work undertaken within the OCHIN network. All three measures taken together would incentivize the intended outcome of the quality measures which is the resolution of HSRNs. OCHIN network members have been pacesetters in digitally documenting HSRN screening and community connection. The establishment of a voluntary Resolution measure provides a critical step forward in building performance measures with clear and demonstrable results.

- FQHC and RHC Codes for RPM/RTM Services. We urge CMS to create specific RTM and RPM reimbursement codes for RHCs and FQHCs. These new codes would be valued separately from the broader G0511 services code and should better reflect the costs and complexity of these services. Separate RTM/RPM codes would mitigate the rationing of care that is likely to occur given the current make-up of G0511. In its present form, G0511 can only be billed once per month despite the increasing number of services providers may offer under the care management umbrella. The ranges of services under this general code means practitioners will now be forced to choose if their patient will receive RPM or social determinant support. In the OCHIN network Medicare beneficiaries often have multiple chronic conditions and social needs, leaving the G0511 code inadequate in covering their care. We join other stakeholders in observing that CMS is allowing non-RHC/FQHC practitioners to bill RPM or RTM concurrently with the following care management services: CCM/transitional care management/BHI, PCM, and CPM. CMS' stated intention "is to allow the maximum flexibility for a given practitioner to select the appropriate mix of care management services, without creating significant issues of possible fraud, waste, and abuse associated with overbilling of these services." We request this same flexibility for services being offered under the G0511 code, so that patients at RHCs and FQHCs are provided the same access to care as other Medicare beneficiaries.