OCHIN

A driving force for health equity

Submitted via regulations.gov

September 9, 2024

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

Re: *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 (CMS-1807-P)*

Dear Administrator Brooks-LaSure,

On behalf of OCHIN, I appreciate the opportunity to provide comments on the *Medicare and Medicaid Programs: Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; etc.* (CY 2025 Medicare PFS Proposed Rule). OCHIN is a **national nonprofit health information technology innovation and research network** comprised of over 2,000 community health care sites with more than 34,500 providers serving 6.3 million patients and includes Critical Access Hospitals (CAHs), rural and frontier health clinics as well as federally qualified health centers (FQHCs) and local public health agencies in 40 states. We applaud the Agency's proposals to expand access to medically necessary dental health services, create bridges to value-based pay models for providers in underserved communities, expand behavioral health services access, and extend COVID-19 PHE flexibilities for FQHCs and rural health clinic (RHC) another year, among other policies that foster greater access to care for the most underserved and rural communities in the nation.

OCHIN: 21ST CENTURY EQUITABLE ACCESS TO HEALTH IT

Since its inception in 2000, the OCHIN collaborative of community providers has focused on expanding access in underserved and rural communities to quality health care services through technology solutions, technical assistance, operational support, informatics, evidence-based research, workforce development and training, and policy. In the OCHIN network, over half of our members' patients are covered under Medicaid, 18 percent are uninsured, 54.3 percent live at or below the federal poverty level, and one in three prefer a language other than English.

OCHIN has also partnered with OSIS, another non-profit technology services organization that is a network of health centers. Together, OCHIN and OSIS collectively support over 39,000 providers serving more than 9.3 million patients. By collaborating to develop affordable and tailored health information technology and services for providers in systemically underserved communities, our partnership with OSIS builds the resilience of both networks and will help transform care for roughly 30% of the estimated 31.5 million health center patients nationwide. Our partnership will also bring greater community healthcare center (CHC) representation to national health equity research and advocacy by augmenting the OCHIN-led **ADVANCE Clinical Research Network** and voluntarily contributing to practice-based research and innovation powered by the largest collection of de-identified community health data in the country.

RECOMMENDATIONS

The following are our overarching recommendations with additional details contained in the **Appendix**. OCHIN urges CMS to:

- **Increase FQHC market basket rate.** We appreciate the payment adjustments made by CMS that would increase base payments for FQHCs under the current prospective payment (PPS) system as part of the regularly scheduled update. But it is critical that CMS explores how it can accurately pay FQHCs by accounting for inflation and historical underpayment. FQHCs continue to face rapidly rising costs associated with delivering care post COVID-19 to some of the most socially and medically complex patient populations. We welcome the 3.5% update to the FQHC market basket rate used to update the FQHC PPS base payment rate; however, many of our members continue to face significant financial stress due to insufficient historical funding at a time when they need resources and funding to support modernization efforts essential to facilitate transitions to value-based payment and delivery models.

- **Extend COVID-19 telehealth flexibilities for FQHCs and RHCs.** OCHIN strongly supports the proposal to extend COVID-19 telehealth flexibilities for FQHCs and RHCs through December 31, 2025. These flexibilities would preserve essential access to care for patients who face significant barriers to care including transportation and housing insecurity. Further, telehealth is an essential tool that could be leveraged to ensure access to specialty care services. Patients served by FQHCs and RHCs continue to face lengthy wait times or forgo specialty care altogether as they lack ready access in their communities and exploring additional options such as expanding access through telehealth is critical.

- **Expand access to dental health services, including FQHCs and RHCs.** OCHIN strongly supports the expansion of medically necessary dental services under the Medicare program. While we applaud the expansion of coverage of dental services to patients with end-stage renal disease (ESRD), we urge the Agency to expand medically necessary dental services and treatment to all patients receiving care from FQHCS and RHCs.

- **Ensure FQHCs and RHCs receive payment that covers the cost of delivering Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) services.** CMS authorized FQHCs and RHCs to bill for RPM and RTM services using a general care management code starting in 2024. CMS is now proposing a new approach to bill for these services and a different reimbursement amount. The proposed change will result in a dramatic decrease in FQHC and RHC reimbursement for these services compared to the CY 2024 rate for RPM and RTMs. As FQHCs and RHCs were only able to start billing for RPM and RTM services last year, the rapid year-over-year changes will destabilize existing programs and create significant confusion and financial strain. To allow providers to prepare for the proposed change, we ask CMS to implement a minimum one-year transition period allowing providers to bill for RTM and RPM services under either the G0511 code or under the proposed individual service codes for CY 2025. In the interim, we also urge CMS to reconsider the proposed amount that FQHCs and RHCs would be reimbursed to ensure it reflects the true cost of delivering these services for higher acuity patients who face more health-related social needs.

- **Provide adequate coverage *and payment* for existing RTM services for mental healthcare.** Our nation more than ever needs accessible interventions to address the opioid crisis that has been ongoing even before the Department of Health and Human Services (HHS) declared it a public health emergency (PHE) in 2017. We applaud CMS' focus on expanding access to RTM for mental health services in light of the PHE. However, the proposed introduction of the different and nearly identical digital mental health treatment (DMHT) codes will create widespread confusion and complexity. We urge CMS to instead price and appropriately reimburse existing RTM codes.

REQUESTS FOR INFORMATION

OCHIN is pleased to provide responses to the following requests for information (RFI) with additional explanation in the Appendix.

- **Services addressing health-related social needs (Community Health Integration (CHI), Principal Illness Navigation (PIN), and Social Determinants of Health (SDOH) Risk Assessment services).** OCHIN encourages CMS to continue implementing codes that capture the full range of social care while highlighting the need for adequate financial support to ensure uptake of these codes, especially amongst healthcare providers in under

resourced settings. We also urge CMS to recognize the impact of community health workers (CHWs) and include them in coding and payment models.

- **Payment for coordinated care and referrals to community-based organizations (CBOs) that address unmet-health related social needs, provide harm reduction services, and/or provide recovery support services.** Harm reduction services are often funded through grants or public health funding rather than billing through insurance. OCHIN urges coverage of such services as these are essential for care.

OCHIN can 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
Chief External Affairs Officer

APPENDIX

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.

Telehealth Services

OCHIN generally supports the proposed updates to policies for Medicare telehealth services.

- Permanently **removing the frequency limitations** for services associated with subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services when provided via telehealth. This flexibility allows specialists who cannot travel to rural hospitals to continue treating patients.
- Revising the definition of an interactive telecommunications system to also **include two-way, real-time audio-only communication technology for any telehealth service** furnished to a beneficiary in their home if the distant site physician is technically capable of using an audio/video system, but the patient is not capable of, or does not consent to, use of video technology. Rural patients already face unique challenges in accessing both in-person and audio-video services leading to inequities in care, such as traveling further distances to receive care. Furthermore, rural areas may lack the broadband infrastructure needed to conduct telehealth visits via non-audio modalities and computer and smartphone ownership among rural residents is lower. **Keeping audio-only as an available modality is important especially for patients and providers, especially those in rural areas, who are not currently able to access and afford broadband services that other telehealth modalities might require.**
- Allowing a **distant site practitioner to use their currently enrolled practice location** instead of their home address when providing telehealth services from their home through CY 2025. At a time where provider burnout is of concern, this flexibility allows health care providers to better support patients while better managing their own stress and burnout. It also has enabled telehealth to expand provider capacity, support patient access to afterhours care from their providers, and can help providers remain in the workforce.
- Permanently **adopting a definition of direct supervision that allows "immediate availability" of the supervising physician/practitioner using audio/video real-time communications technology** for a subset of incident-to-services while continuing to define "immediate availability" to include real-time audio/visual interactive communications technology only through December 31, 2025, for all other services required to be furnished under direct supervision. This will allow FQHCs and RHCs to improve patient care as they will be able to better optimize staff, enhance communication, and reduce provider burden.

Digital and Telehealth Services for FQHCs and RHCs

OCHIN supports continuing to allow FQCHs and RHCs to bill for telehealth visits to ensure rural beneficiaries retain access. CMS proposed to continue allowing FQHCs and FQHCs to bill for telehealth visits using the G2025 code and be paid the current rate based on the average amount for all MPFS telehealth services. However, they also proposed an alternate proposal amending the definition of a "visit" to include audio-video telehealth, which would allow FQHCs and RHCs to be reimbursed under their specific methodology (PPS for FQHCs and the All-Inclusive Rate for RHCs) at the per visit payment rate. **OCHIN supports this alternate proposal to amend the definition of a "visit" to include telehealth, which would provide payment parity for the same services furnished by FQHCs and RHCs regardless of delivery modality and is not currently available to FQHC and RCH providers even under temporary Medicare allowances**. Payment parity provides an incentive to invest in using technology in health care delivery and allow them to keep pace with other health care providers and improve/expand access to patient care.

OCHIN supports delaying the in-person mental health visit requirement for mental health services furnished via telehealth by RHCs and FQHCs to Medicare beneficiaries until January 1, 2026. If the in-person requirement went into effect on January 1, 2025, Medicare beneficiaries may experience a lapse in care. Extending the flexibility for telehealth mental health services helps mitigate the impact of social drivers of health, including limited access to transportation, which can prevent individuals from seeking necessary mental health care and pose challenges to

meeting the in-person requirement. Furthermore, telehealth has become integral to the delivery of mental health care for RHCs and FQHCs. This extension allows them to help meet patients where they are and continue furnishing needed mental health services.

Proposed Payment Policy for General Care Management Services (G0511)

OCHIN urges an alternative approach to the Agency's proposal to require RHCs and FQHCs to bill the individual codes that make up the general care management HCPCS code, G0511. The addition of new codes in the past years to G0511 has complicated billing for these services. To allow providers to prepare for the proposed change, we ask CMS to implement a minimum one-year transition period allowing providers to bill for RTM and RPM services under either the G0511 code or under the proposed individual service codes for CY2025. In the interim, we also urge CMS to reconsider the proposed amount that FQHCs and RHCs would be reimbursed to ensure it reflects the true cost of delivering these services for higher acuity patients who face more health-related social needs.

We urge CMS to ensure payment rates accurately reflect the cost of providing the different general management services as CMS calculates the reimbursement rates for each of these services. RTM and RPM, for example, has been flagged to potentially generate lower reimbursement rates than the CY2024 which could impair the ability of providers, especially FQHCs and RHCs ability to provide this service to their patients. RTM and RPM drive improved health outcomes in key areas of high disease burden for FQHCs and RHCs such as chronic conditions and behavioral and mental health conditions. This change follows the first year of eligibility for FQHCs and RHCs billing for RPM and RTM and will likely disrupt many providers who are in the process of expanding RPM and RTM access to halt their plans. Therefore, we ask CMS to provide sufficient reimbursement for all services previously bundled under G0511.

We ask CMS to implement a one-year transition period at a minimum where providers may either bill for RPM and RTM services under the G0511 code or under the individual service codes proposed for CY 2025. This will allow patients to continue accessing care management services and give providers time to transition to the proposed changes. Furthermore, it will ensure patients who may start RTM and RPM in 2024 can continue to receive services without disruption into 2025 as reimbursement models change.

Proposed Advanced Primary Care Management Services for Existing APM Models

We ask CMS to clarify how billing for advanced primary care management (APCM) services will interact with billing for services under the existing APM Models. CMS has proposed new APCM codes that can only be used by providers participating in a subset of Medicare APM models. We seek clarification on how these codes will interact with the payment structure of these models. Using the MCP as an example, participants receive a prospective primary care payment (PPCP) and an enhanced services payment (ESP). We ask CMS to clarify whether MCP participants who furnish APCM services will receive payment for those services *in addition* to their PPCP and ESP payments under the program.

The proposed reimbursement for GPCM1 ($10), GPCM2 ($50), and GPCM3 ($110) are insufficient. The proposed APCM services are more intensive and require more specific documentation than general care management services. We are concerned that the low reimbursement rate does not accurately reflect the complexity of care, nor the administrative burden placed on FQHCs and RHCs. The APCM services are already more complex than some of the general care management services that FQHCs and RHCs provide. We ask CMS to consider raising the payment rate for the APCM bundle to better account for patient care costs and **recommend developing additional technical assistance that would help FQHCs and RHCs better understand this new APCM bundled payment option in the context of the APM models these codes are limited to**.

Cost-sharing may be a burden for FQHC and RHC patients – we ask CMS to allow a co-insurance waiver for FQHC and RHC patients who consent to using APCM services. While we support obtaining patient consent for APCM

services to inform patients of the monthly cost-sharing responsibility as FQHCs and RHCs are accustomed to obtaining patient consent prior to providing high-touch services, we are concerned how this will impact accessibility for patients. Many FQHC and RHC patients are already financially vulnerable. Additional cost-sharing responsibilities could cause patients to disenroll or otherwise interrupt care if they receive a monthly bill. **By waiving the co-insurance costs of APCM for our patients, this reduces the financial barriers to care and will help ensure patient enrollment in continuing to receive these services**.

We also ask CMS monitor and evaluate the implementation of APCM services as well as usage at RHCs and FQHCs to determine other potential barriers to uptake and whether changes are needed to APCM services to make them more accessible to rural patients. Ultimately, the elements of these advanced primary care management services could help increase screening rates and improve care of chronic conditions such as hypertension and diabetes.

Intensive Outpatient Program Services (IOP) in RHCs and FQHCs

OCHIN supports CMS' proposal to add a payment rate for FQHCs and RHCs for days with four or more services. By allowing RHCs and FQHCs to bill for 4-service days, we hope it will encourage rural uptake by providing parity and site-neutral payments for IOP services across different settings. FQHC and RHC patients already have more complex conditions than other patient populations. As such **FQHCs and RHCs must be adequately compensated for all costs associated with providing the intensive level of care that a patient receives through IOP services**.

RHC Productivity Standards

OCHIN supports CMS' proposal to remove productivity standards for RHCs. RHCs are currently subject to productivity standards that can impact on their payment if not met. With the Consolidated Appropriations Act of 2021 restructuring the RHCs payment limits, we agree with CMS' reasoning that there is no longer a need for productivity standards for RHCs as they are outdated and redundant.

FQHC Market Basket

OCHIN supports the Agency's proposal to rebase and revise the FQHC market basket from a 2017 base year to 2022. FQHCs have historically operated on thin margins because of their federal mandate to treat all patients regardless of ability to pay. Furthermore, **health centers continue to experience unprecedented financial constraints following the Medicaid unwinding, which could cause the nation's CHCs to eventually lose $1.5 billion to $2.5 billion in patient revenue, and rising costs of inflations**.[1] Given Medicare consists of fifteen percent of total patients at roughly one in five health centers, the market basket update will help ensure Medicare payments to FQHCs accurately reflect the true cost of providing care in a health care setting.[2] Furthermore, Medicare patients are the fastest growing segment of health centers' population making it imperative that they are reimbursed for all costs associated with proving care for Medicare beneficiaries.

We strongly support CMS' inclusion of telehealth services in the 2022-based market, which reflects the regulatory changes and expansion of telehealth services that occurred that year. Telehealth has become essential to overcoming barriers to healthcare access, including geographic, economic, linguistic, and transportation, especially given FQHCs are required to provide comprehensive services to high-need areas. **By including telehealth services in the market basket, CMS' underlines its importance in maintaining and expanding access to care**, ensuing FQHCs can continue to meet the evolving needs of their patients, especially patients in underserved communities.

[1] https://geigergibson.publichealth.gwu.edu/potential-effect-medicaid-unwinding-community-health-centers
[2] https://www.nachc.org/policy-advocacy/health-insurance-reimbursement/medicare/

RHC and FQHC Conditions for Coverage – Provisions of Services

OCHIN supports the Agency's proposal to change the *Provision of services* Conditions for Coverages to explicitly require RHCs to provide primary care services; however, we *do not* support this provision for FQHCs as it may unintentionally prohibit the existence of behavioral health-only FQHC sites in Medicare. While we understand CMS' reasoning for amending the regulatory language to allow RHCs to offer more specialty services without being restricted to needing to be "primarily engaged in furnishing primary care services," FQHCs are also subject to these Conditions for Coverage requirements. Amending this provision would be restrictive for FQHCs as it could inadvertently preclude Medicare-enrolled behavioral health-only sites for FQHCs – limiting each FQHC site by requiring them to provide the medical component of FQHC services as well. These services and sites are a critical part of comprehensive care FQHCs provide, especially in underserved areas.

The proposed changes include specific language for RHCs, stating that they cannot be rehabilitation agencies or facilities primarily for the care and treatment of mental disease – this comes from the Social Security Act.[3] This restriction does not apply to FQHCs under this statute, which makes an implicit extension to FQHCs through these regulatory changes problematic. CMS does not have the explicit authority to do so for FQHCs and implementing this change would have significant consequences for FQHCs that focus solely on behavioral health services and hinder access to essential behavioral health services, especially in areas where there already exist considerable barriers to healthcare access.

Our nation is currently undergoing an opioid crisis and FQHCs play a crucial role in addressing this crisis, often serving patients who may not have access to other access to healthcare settings. The Agency's proposed language change is concerning because the statutory requirements for FQHCs do not impose the same restrictions as those for RHCs. FQHCs are designed to provide a broad range of services, including behavioral health, without a statutory mandate requiring each site to provide medical services. **We urge CMS to review the proposed revisions and make any changes needed to ensure FQHCs can continue meeting the needs of their communities, including through behavioral health-only sites.**

Laboratory Requirements for RHCs

OCHIN supports CMS' proposals to remove hemoglobin and hematocrit (H&H) tests from the list of diagnostic laboratory tests RHCs must provide directly. As the H&H test is typically performed as part of a comprehensive blood count, which RHCs typically refer to the nearest hospital, removing this test would provide regulatory relief to RHCs.

Fee Schedule for Drugs Covered as Additional Preventive Services (DCAPS)

OCHIN supports CMS's proposal for a fee schedule for DCAPS drugs that uses existing Part B mechanisms. Historically, FQHCs and RHCs have not received a separate payment for physician-administered drugs in the past CMS' creation of billing mechanisms for HCAPs physician administered drugs and key vaccines within office visits (outside of the cost report) supports FQHCs and RHCs and ensures their financial sustainability. This will help decrease preventive care costs for Medicare beneficiaries and increase payment for those providing services. We also appreciate CMS' clarification that DCAPs and any accompanying administration and supplying fees are not subject to cost-sharing in FQHCs. **We do ask CMS to provide clarity around DCAPS:**

- Is there a specific way FQHCs and RHCs will be able to access these medications?
- What other drugs will be included under this designation? If so, will CMS publish a list?

[3] Social Security Act 1861(aa)(2)(A)

Dental and Oral Health Services

OCHIN strongly supports and applauds CMS's proposal to adding care related to the of end-stage renal disease to the list of clinical scenarios under which FFS Medicare payment may be made for dental services linked to covered services. We support adding (1) dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease; and (2) medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for **beneficiaries with end-stage renal disease** to the list of clinical scenarios under which FFS Medicare may be made for dental services inextricably linked to covered services.

OCHIN strongly urges CMS to consider adding dental services and covered services used in the treatment of diabetes to the list of clinical scenarios under which FFS Medicare may be made for dental services inextricably linked to covered services. Research has shown a **strong connection between diabetes and periodontal disease**, as uncontrolled periodontitis can negatively affect glycemic (HbA1c) control and patients with diabetes have an increased risk for developing chronic periodontitis.[4,5] However, proper dental treatment can control periodontal disease and in turn, lower HbA1c levels. The evidence demonstrates patients with diabetes, especially those with poor glycemic control, should check their oral hygiene and periodontal status, as well as receive routine periodontal therapy at least once a year.[2] In the OCHIN network, there are members who take the HbA1c levels of patient while they are in the chair at the dental clinic, as part of their dental visit, to screen their patient for diabetes and connect them with the medical team, if needed. Given the significant prevalence of diabetes in the patient population we service, provision of dental services is essential.

Additionally given the age demographics of Medicare beneficiaries, conditions, such as arthritis, and medications, such as those for high blood pressure, can impact dental and oral hygiene. For example, high blood pressure can result in medication-induced xerostomia which increases the risk of losing teeth due to carries. Arthritis likewise can contribute to **age-related limitation on activities of daily living making it more challenging for patients to brush their teeth and can lead to poor oral hygiene** if they cannot brush or floss their teeth properly.

Dental and Oral Health Services for FQHCs and RHCs

OCHIN supports CMS' clarification that when RHCs and FQHCs furnish covered dental services these would be considered a qualifying visit and be paid at the RHC AIR methodology or FQHC PPS. Allowing FQHCs and RHCs the opportunity to bill for these services ensures parity amongst all Medicare providers furnishing these specific dental services. CMS' decision to allow the furnishing of visits to qualify as a visit is critical to ensuring equitable access to care for all Medicare beneficiaries. FQHCs and RHCs serve as a safety-net for millions of low-income and uninsured individuals, who present with complex medical needs, including dental. Aside from parity amongst Medicare providers, this decision will alleviate the financial burden on FQHCs and RHCs, allowing them to continue providing whole-person comprehensive care.

OCHIN encourages CMS to allow medical and dental visits furnished on the same day to be paid separate rather than payable as one visit. Separate payment for each visit type would ensure sustainability in providing dental services in RHC and FQHC settings. Many patients, especially those in underserved areas, already face social determinants of health-related barriers in accessing care (transportation, economic, geographic, etc.). By allowing patients to schedule multiple visits a day, they can take care of their health care needs, both medical and dental, in one day. Allowing FQHCs and RHCs to bill for same-day medical and dental visits helps improve care coordination services that already exist within the services they provide. Given their already narrow operating margins, this policy change to allow FQHCs and RHCs to bill under their respective payment methodologies contributes significantly to their financial stability. This also allows for accurate reflection of the actual time and resources invested in each patient encounter. **We strongly support the policy allowing FQHCs and RHCs to bill separately for same-day visits and hopes CMS adopts this as another exception to the same-day visit limitation.**

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9954907/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8099950/

Expanding Colorectal Cancer Screening

OCHIN supports CMS' proposal to update and expand coverage of colorectal cancer (CRC) screening. CMS' addition of Computed Tomography (CT) Colonography and expanding their approach to a "Complete CRC Screening", which includes that a follow-on colonoscopy would not incur beneficiary cost-sharing will **increase access to CRC screening** that provides much needed prevention and early detection, especially **within rural communities and communities of color that are disproportionately impacted by CRC incidence.** [6]

Cardiovascular Risk Assessment and Risk Management

OCHIN supports CMS allowing FQHCs and RHCs to bill for the proposed new stand-alone G-code, HCPCS code GCDRA, and Administration of a standardized, evidence-based Atherosclerotic Cardiovascular Disease (ASCVD) Risk Assessment for patients with ASCVD risk factors. FQHCs and RHCs serve medically complex patients that are more likely have been diagnosed with diabetes mellitus, asthma, high cholesterol, or hypertension as compared to the rest of the nation.[7,8] These are conditions cited in the proposed rule that could result in the need for an ASCVD Risk Assessment, highlighting the importance of including FQHCs and RHCs in administering and billing for this risk assessment when conducting an E/M visit.

Advancing Access to Behavioral Health Services

As the United States continues to grapple with the ongoing opioid crisis, OCHIN is encouraged to see the proposed changes to increase behavioral access in Medicare but strongly recommends CMS include RHCs in their ability to utilize the proposed codes for safety planning interventions, and post-discharge telephonic follow-up, digital mental health treatment, and interprofessional consultation billing by practitioners.

The opioid crisis has been ongoing since HHS declared it a PHE in 2017, highlighting a drastic need for accessible, community-based, and comprehensive mental and behavioral health care, especially in rural and underserved areas. FQHCs and RHCs are uniquely positioned to directly integrate mental health and primary health care service in a patient-centered and community-based setting. Any recommendations related to care integration that prioritizes mental health need to consider the ability of FQHCs and RHCs to improve the quality and availability of care.

OCHIN supports CMS' proposal to create an add-on G-code, HCPCS code GSPI1, for safety planning interventions and the monthly billing code, HCPCS code GFCI1, for post-discharge telephonic follow-up contacts. We also strongly recommend CMS amend these sections to include RHCs and FHQCs as eligible providers to use these codes. An FQHC mental health visit, as of January 2022, is defined as a face-to-face encounter or an encounter furnished using interactive, real-time audio and video telecommunications technology or, in some cases, audio-only technology. However, Medicare regulations limits FQHC mental health visits to a narrow range of services and only recognizes narrow group of behavioral health clinicians. While practitioner groups may use a wider range of workforce as "auxiliary personnel" who are paid for on an "incident to" basis under the Physician Fee Schedule, FQHCs do not benefit from that flexibility as health center visits must include direct involvement by the billable FQHC clinician.

Suicide is one of the leading causes of deaths in the United Deaths, with increased rates among adults aged 65 and over.[9] Primary care is the most likely point of contact for suicidal patients in the healthcare system with 77% of patients who die by suicide visiting primary care in the prior year and 45% visiting a primary care office within the

[6] https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-cancer-outcomes-screening-and-treatment/#:~:text=Racial/ethnic%20patterns%20of%20colon%20and
[7] https://healthcare.rti.org/insights/chronic-disease-and-rural-health-disparities
[8] https://www.nachc.org/wp-content/uploads/2024/07/2024-2022-UDS-DATA-Community-Health-Center-Chartbook.pdf
[9] https://www.cdc.gov/suicide/suicide-data-statistics.html

month prior to their death.[10,11] CMS must ensure the FQHC primary care network, as well as the RHC network, is include to ensure that this suicide and risk prevention strategy reaches those who need it most.

OCHIN requests guidance on how these codes would integrate with reimbursement for transitional care management service even though these codes do focus on risk of suicide and other crisis care needs. Individuals with opioid use disorders and chronic pain are also at increased risk for suicide.[12]

The proposal would provide administrative support to health centers that provide crisis care. Health centers can provide access to Medication for Opioid Use Disorder (MOUD) services and are key access points to patients regardless of their ability to pay. Safety planning interventions and post-discharge telephonic follow-ups for crisis care meet the needs of patients when they are most vulnerable to prevent deliberate self-harm. Payment arrangements with cost-sharing may inadvertently create a barrier to extremely necessary care and support. **Therefore, we also urge CMS to find an alternative payment methodology for these crisis code services that offer flexible payments, so patients are not disincentivized to seek help, especially given the sensitive nature of these services.** We recommend implementing a set number of calls per month or other specified duration before requiring beneficiary cost-sharing.

OCHIN offers the following responses in CMS's **request for comments regarding the proposed G-code, HCPCS code GSPI1G-code for safety planning interventions**:

- **Proposed Timeframe of 20 minutes:** Clinicians routinely review and update safety plans when patients are at moderate or high-suicide risk; therefore, we commend CMS change the time for the code safety-planning code from 20 minutes to 20-60 minutes with the option of an additional add-on code.
- **Context of an Encounter:** The six steps of the Stanley-Brown Safety Plan require documentation since the plan is shared with the patient, with most information in the plan reflecting the patient's words. The intervention typically occurs within the context of an encounter, such as an E/M visit or psychotherapy. If a patient is assessed to be moderate or high-risk based on a standardized suicide screen assessment, such as the Columbia Suicide Severity Rating Scale, the clinician and the patient would engage in safety planning. Since the clinician is evaluating suicide risk during an encounter, safety planning occurs as best practice. Notably, safety planning can occur at multiple visits, as a patient may have created a safety plan during an encounter but may need to update their plan at a subsequent encounter.
- **Clinician Types:** Clinician types most likely to bill would be psychiatrists (MD/DO), PMHNPs, LPCs, LMHCs, PhDs, PsyDs, LCSWs, RNs, LMFTs, and other therapists.

We offer the following responses to CMS' **request for comments regarding the proposed monthly billing code, HCPCS code GFCI1 for post-discharge telephonic follow-up**:

- **Specified duration:** If the code were to be implemented, a two-three per calendar month time would be appropriate. One challenge of obtaining consent for this proposed intervention is emergency department clinicians would be separate from the providers performing outreach.
- **Threshold to bill:** There is concern with the proposed price being linked to the CPT code 99426, as the complexity of caring for someone after a discharge from the emergency department with a mental health crisis may exceed the complexity of a typical encounter coded as a 99426 with a patient who has not been recently discharged from an emergency setting. Furthermore, a challenge with this proposed code would be unsuccessful phone call attempts to the patient. Since the calls would be unscheduled, there is a greater likelihood the clinician would not be able to connect with the patient.

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9196265/#B6
[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5072576/
[12] https://www.nimh.nih.gov/about/director/messages/2019/suicide-deaths-are-a-major-component-of-the-opioid-crisis-that-must-be-addressed#:~:text=Individuals%20suffering%20from%20chronic%20pain

Ultimately, these codes will provide administrative support to providers furnishing crisis care. However, we do raise that adding the G-codes may contribute complexity and administrative burden to the provider workflow. Increased documentation can also lead to more time spent on paperwork rather than patient care. G-codes can also increase the potential for error given their complexity and specificity, which can result in claim denials or delay in reimbursement. Staff may also require additional training to correctly use G-codes, which increases costs and time spent on education. The introduction of G-codes can also result in disruptions and confusion in billing practices, which in turn could shift the focus from patient care to administrative tasks, emphasizing proper coding and billing and potentially affecting quality of care

Digital Mental Health Treatment (DMHT)

While OCHIN supports the creation of digital mental health treatment (DMHT) codes that will help increase behavioral access to Medicare beneficiaries, especially in rural areas, we are concerned by the complexity and confusion regarding the creation of these codes. CMS proposal to create three new HCPCS G-codes (GMBT1, GMBT2, and GMBT3) for DMHT devices lacks specificity and would overlap or duplicable existing CPT codes, which could introduce confusion and complexity with regards to billing and payment. Instead, CMS should provide payment for CPT Codes 98978 as devices required by this code are medical devices as defined by the Food and Drug Administration. This means that they must meet regulatory requirements already established by the FDA regarding their safety and effectiveness for their intended use. CPT Code 98978 pertains to the supply of a medical device(s) that provides a therapeutic intervention and support monitoring. As this is a Category 1 code, CMS may start paying this code starting January 1, 2025, which would allow physicians and practitioners to have immediate coverage and payment for cognitive behavioral therapy (CBT) monitoring and intervention starting January 1, 2025.

Our nation more than ever needs accessible interventions to address the opioid crisis that has been ongoing even before the Department of Health and Human Services (HHS) declared it a public health emergency (PHE) in 2017. We applaud CMS' focus on expanding access to RTM services for mental health services in light of the PHE. **Given the similarities between GMBT1 and the existing CPT codes support our ask that CMS instead expedite the immediate payment of the existing CPT 98978 code, which can be used in conjunction with 98975 (set-up), 98980 (initial 20 minutes work), and 98981 (each additional 20 minutes work), which are already active and paid.**

Interprofessional Consultation Billed by Practitioners Authorized by Statute to Treat Behavioral Health Conditions

OCHIN strongly supports proposed payment for interprofessional consultations billed by practitioners authorized by the statue for the diagnosis and treatment of mental illness. CMS will need to add these proposed G codes to an FQHC-qualifying visit[13] and RHC-qualifying visit as well as the specific providers to the core providers list. Addition of these new codes would allow new billable providers in Medicare, including clinical psychologists, social workers, marriage and family therapists, and mental health counselors, to bill for interprofessional consultations with other practitioners for diagnosis and treatment of mental illness. These interprofessional consultant codes also align with CMS' efforts in the Medicaid space. **We are supportive of these G-codes and their availability to both the treating/requesting practitioner and the consulting provider**. The proposed time increments will provide better flexibility to the providers and are appropriate for varying care and consulting needs. Consultation is a key part of assessment, treatment, and ongoing care – we appreciate policies that will make interprofessional consultations more efficient and enhance care coordination.

We request clarity on whether the treatment/requesting practitioner and the consulting providers must be in the same organization to bill these new G codes. Rural counties are more likely to have a disparate distribution of mental health workers, including nurse practitioners, social workers, and counselors. Interprofessional consultations will allow better sharing of mental health expertise, which will help achieve better healthcare outcomes, especially for rural patients. Interprofessional consultations can enhance timely access to mental and

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

behavioral healthcare services, lessening the need for an in-person referral or visit, allowing for shorter wait times, and supporting team-based care.

Although FQHCs and RHCs are authorized to participate in Medicare monthly care management programs, including those for behavioral health, payment is not at parity with Part B physician groups. **OCHIN recommends that the advancing access to behavioral health services proposed changes in the CY 2025 PFS be amended for better inclusion of FQHCs and RHCs to improve their financial sustainability and expand mental health integration in primary care and for safety net providers.**

Caregiver Training Services

OCHIN supports CMS' proposal to create a new coding and payment for caregiver training for direct care services and supports as we all as one for caregiver behavior management and modification training that could furnished to the caregiver(s) of an individual patient – we also support the addition of these to the Medicare Telehealth List. Caregivers are an essential part of a patient's care team that have historically been overlooked and unsupported. The growing Medicare population also highlights an increase in the numbers of caregivers. Nearly one in five caregivers are providing care to an adult with health or functional needs.[14] Only 7 percent of receive caregiver-related training, which could help improve the care they provide.[15] The proposed payments will help ensured continued support of caregivers. We encourage CMS to raise awareness of these caregiver-specific services among beneficiaries and healthcare providers.

[14] https://www.caregiving.org/research/caregiving-in-the-us/caregiving-in-the-us-2020/#:~:text=The%202020%20update%20reveals%20an%20increase%20in

[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6547146/#:~:text=Multivariable%20logistic%20regression%20was

REQUESTS FOR INFORMATION

Services Related to Services Addressing Health-Related Social Needs (CHI, PIN, SODH Risk Assessment)

Barriers to furnishing the services addressing health-related social needs and if established codes allow practitioners to better address unmet social needs that interfere with their ability to diagnose and treat the patient

- **The implementation of the newly established newly established codes (Community Health Integration (CHI) (HPCCS codes G0019, G0022), Principal Illness Navigation (PIN) (HCPCS codes G0023, G0024), Principal Illness Navigation- Peer Support (PIN-PS) (HCPCS codes G0140, G0146), and Social Determinants of Health Risk Assessment (SDOH RA) (HCPCS code G0136)) is a strong step in ensuring that health care settings that have been providing these services can document this care delivery in a systemic manner. OCHIN continues to encourage the implementation of codes that capture the full range of social care, including addressing social needs and/or referring to community partners when available.** We also acknowledge, however, that capturing the full range of social care may inadvertently disadvantage those settings that are under resourced to provide this care. Healthcare organizations in areas with a dearth of local services that can be used to address these needs (e.g., an affordable housing shortage makes it hard to address housing needs) are a substantial barrier and source of concern to ensure that clinics are not penalized for this. This may also be amplified by the type of need, acuity of the need, and availability of services that can make it challenging to implement these codes in a systematic way. Further, implementing social care tasks often requires substantial support. OCHIN's qualitative research has found that health centers may benefit from leadership support, established community partnerships, and training approaches incorporating workflow redesign, written step-by-step guidance, and a combination of EHR demonstration and hands-on practice before implementing approaches to social care. Therefore, **new codes and expectations of their use should be paired with adequate financial incentives to ensure their success.** Finally, we must acknowledge that not all patients with social risks will desire support. Implementation of reporting requirements should not penalize clinics that have high rates of patients with social risks but low referral rates, driven by patients not desiring help.

Auxiliary personnel that provide services addressing health-related social needs

- **Auxiliary personnel, such as community health workers (CHWs), medical assistants, rooming staff, care managers, social workers, and patient navigators should be adequately captured in current coding and payments for services addressing health-related social needs.** For community-based health care organizations, we find **CHWs and other similar professionals are often engaging the most meaningfully with patients regarding social risk screening and addressing identified needs**. However, **there is substantial variation in the use of CHWs and other similar professionals for these tasks, and their ability to use electronic health records and billing.** As coding and payment models develop, it is vital to ensure that CHWs and other similarly trained personnel can engage with these advancements and contribute to the documentation of these codes. Current barriers to staff engagement include lack of access to the EHR and other platforms and the regulatory authority to document using these codes. Policy advancements in this space must consider this as a source of variation across care settings.

Relationships between community-based organizations (CBOs) and billing practitioners

- **Many community-based health care organizations in the OCHIN network and other CHCs have, or are, partnering with CBOs that provide social services for historically underserved patients.** Our research shows that strong relationships with CBOs are essential to effective social needs referral-making, regardless of integrated social service resource locator (SSRL) use (Launch, Findhelp Native+). These efforts, including connecting patients to these CBOs and the subsequent results, are not always systemized or documented in a way that allows for ready, accurate reporting. This is driven by the need for implementation support to make this change, the electronic health record (EHR) not being equipped to support CBO referral, and a lack of financial incentives to implement these needed changes. **As progress continues in understanding the relationship between these CBOs and community-based health care organizations, we encourage CMS to**

ensure flexibility in the definitions and data collection requirements so that those in under resourced settings can accurately capture and report these partnerships. Furthermore, we need innovative approaches to ensure CBOs are equipped with the resources to systematically provide "closed loop" feedback to enhance data for reporting.

Coding Z-codes on claims associated with billing for CHI, PIN, and SDOH risk assessment codes

- **Z-codes continue to be underused even in care settings that serve a high volume of patients with social needs– such as the community-based health care organizations**, including in the OCHIN network. While the exact cause of the underuse of Z-codes is not fully understood, it is likely due to current optional use of these codes, lack of incentive to use them, and lack of resources to refer patients. Patients with social risks often have greater medical complexity; therefore, those complex medical conditions are given a higher priority in billing. **To increase the use of Z-codes these codes must be coupled with reimbursement or adjustment that would create incentives, and provide the needed resources, to routinely document these codes**.

Barries to improving access to high-value, potentially underutilized services by Medicare beneficiaries

- **Key barriers to implementing social risk screening include the lack of available services and services that may oftentimes fluctuate over time as well as interoperability concerns between social service resource locators (SSRLs), EHRs, and community-based organizations (CBOs) main data systems.** Further, a single patient will often present with co-occurring social risks that may require multiple connections to CBOs – presenting an even greater challenge to measure referral and closed loop resolution. Finally, just referring patients to social risks may not result in accessing those services or resolution of those needs, but **we should continue to ensure that navigation-related tasks are financially incentivized and recognize that there may only be incremental changes in measured, health care patient outcomes.**

Barriers to provision of evidence-based care for persons with fractures

- **While ensuring a code is a first step for managing fractures under a treatment plan, including the proposed global post-operative add-on code (HCPCS code GPOC1), we also encourage financial incentives coordinating care** (i.e. ensuring adequate transmittal of clinical information such as laboratory studies and medication administration of bisphosphonate) between the primary care provider, the hospitalist, the orthopedic surgeon, the place where rehabilitation may take place (i.e. skilled nursing facility), or another specialist such as an endocrinologist or geriatrician. **This should also include increased health information exchanges between these various care settings and providers**. Guidelines recommend initiating bisphosphonate therapy for patients with fragile fractures within two to 12 weeks of the fracture, during a time when patients may be in a Skilled Nursing Facility, with infrequent physician/laboratory study oversight.

Payment for Coordinated Care and Referrals to Community-Based Organizations that Address Unmet Health-Related Social Needs, Provide Harm Reduction Services, and/or Provide Recovery Support Service

Other public or privately funded OTP sources of fundings for coordinate care and referral services

Many harm reduction services, including syringe exchange and naloxone distribution, receive funding through state or federal grants, public health departments, or non-profit organizations rather than relying solely on billing through insurance. Opiate treatment programs (OTPs) provide syringe exchange services that reduce the transmission of infectious disease and safely collect used syringes. These services are often funded through grants or public health funding rather than direct billing.

However, case managers and social workers in OTPs can use a variety of billing codes to coordinate care and make referrals to community-based organizations (CBOs). Case managers commonly use codes for telephone assessment and management services provided by non-physician healthcare professionals. These codes can include:

- **CPT Code 98966:** Covers 5-10 minutes of telephone assessment and management services.

- **CPT Code 98967:** Covers 11-20 minutes of telephone assessment and management services.
- **CPT Code 98968:** Covers 21-30 minutes of telephone assessment and management services.

To bill for **social determinants of health and community-based referrals**, OTPs can use the following
- **HCPCS Code G9001:** Coordinated care fee for individual assessment and care planning that is often used for initial assessments.
- **HCPCS Code G9008:** For care coordination of health-related social needs, which may include referrals to community-based organizations.

There are **several codes related to harm reduction services including provision of naloxone**. OTPs provide naloxone kits, which include naloxone to individuals at risk of overdose and their families. They also offer training on how to recognize an overdose and properly administer naloxone. The following codes can be used to bill for harm reduction services:
- **CPT Code 99401:** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual, approximately 15 minutes.
- **CPT Code 99402:** Approximately 30 minutes.
- **HCPCS Code G2067:** Medication-assisted treatment, including the use of methadone, with care coordination and counseling services. This can sometimes encompass harm reduction education and naloxone training.

Naloxone can also be billed through pharmacy benefits using NDC codes, especially when dispensed as part of a prescription benefit. Additionally, **OTPs can bill when providing harm reduction services related to education and linkages to care** as OTPs connect clients to additional medical, mental health, and social services, including primary care and behavioral health treatment. The following codes can be used related to education and linkages to care.
- **CPT Code 99406:** Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. Similar codes can be applied for other substance use education.
- **HCPCS Code H0020:** Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program).

The following codes can be used when **billing for recovery support services related to peer support services**:
- **HCPCS Code H0038:** Self-help/peer services, per 15 minutes. Used for billing peer support services.
- **HCPCS Code S9445:** Patient education, not otherwise classified, non-physician provider, individual, per session.

The following codes relate to **skill-based group therapy**:
- **CPT Code 90853:** Group psychotherapy (other than a multiple-family group).
- **CPT Code 90849:** Multiple-family group psychotherapy.
- **CPT Code 90834:** Individual psychotherapy, 45 minutes. Can be applied to individual skill-building sessions if needed.

The code below relates to **case management and coordination**:
- **HCPCS Code T1016:** Case management, each 15 minutes. Used for coordination of care and connecting clients to resources.

For **education and workshops**, the following codes are available:
- **HCPCS Code G0176:** Activity therapy, such as music, dance, art, or play therapies not for recreation, related to the care and treatment of the patient's disabling mental health problems, per session.
- **CPT Code 98960:** Education and training for patient self-management by a qualified, non-physician healthcare professional using a standardized curriculum, face-to-face, individual, per 30 minutes.