

Coding, Coverage, and Payment to Improve Inclusive Health

Report Prepared for Special Olympics

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Contents

Acknowledgements and Disclaimer	3
Executive Summary	4
Background and Approach to Analysis.....	8
Methods	9
Findings.....	11
Care Model Elements and Barriers Impacting Their Use	11
Coding Opportunities in Fee-For-Service and Value Based Payment	13
Barriers to Coding for Inclusive Health	17
Opportunities Identified by Stakeholders.....	19
Key Takeaways.....	23
Potential Solutions.....	24
Cover additional services needed to achieve care models consistent with principles of Inclusive Health.	24
Provide sufficient payments that account for the significant costs and the flexibility needed to implement Inclusive Health-driven care models.	26
Reduce administrative burdens for clinicians and staff who serve individuals with I/DD.....	26
Increase training of clinicians and staff to enhance the workforce who can execute Inclusive Health- driven care models and increase education of payers to support provider and practice innovation..	27
Conclusion	28
Appendix.....	29
Example of Coding Requirements – Medicare Chronic Care Management	29
CY 2025 Medicare Physician Fee Schedule (PFS) Coding Additions	31
About Leavitt Partners	33
About Health Management Associates.....	33
About Institute for Exceptional Care.....	33
References	34

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EXECUTIVE SUMMARY

People with intellectual and/or developmental disabilities (I/DD) deserve to be healthy and to have access to a health care system that meets their unique needs. In the United States, the more than 6.4 million Americans with intellectual disabilities and 10–16 million people experiencing I/DD, face disproportionate difficulties in accessing high-quality care, marked by poorer health outcomes, higher numbers of chronic conditions, and, ultimately, shorter lifespans.

To improve individual experiences and population health outcomes for people with intellectual disabilities, Special Olympics has promoted the concept of Inclusive Health, which health care clinicians and practices can utilize to ensure that people with I/DD have equitable access to, and can fully participate in, their own health care decisions. The principles of Inclusive Health include elements that clinicians and practices currently struggle to provide, including:

1. Welcoming spaces (ensuring that the physical environment is accessible),
2. Communication that ensures both spoken and written communications are accessible and provide supports for individuals,
3. Awareness and training for staff and leaders about the barriers for people with ID and ways to overcome those barriers, and
4. Sustainable and intentional inclusion of people with ID and ID organizations in policy and systems as well as in care decisions.

With the goal of evaluating the use and potential for coding mechanisms that would reduce barriers individuals with I/DD face in care consistent with the Inclusive Health model, Special Olympics contracted with Leavitt Partners, Health Management Associates, and Institute for Exceptional Care (the team) to conduct a coding analysis, literature review, and interviews with experts, including clinicians, payers, patient advocates, and government officials. Through the analyses and interviews, the team arrived at findings on the elements needed to establish a holistic model of inclusive care; gaps in coding, coverage, and payment that affect its implementation; and actionable policy recommendations to improve coverage and payment, reduce burdens, and educate stakeholders.

Overall, the interviews and analysis provided information on how to structure care models to meet the needs of individuals with I/DD, as well as opportunities now available to code for services and use value-based payment (VBP) arrangements.

- **Clinicians identified key facilitators for implementing Inclusive Health-driven care models.** Clinicians interviewed have employed a number of strategies to improve care for individuals with I/DD and noted core care model elements that could be better used across the board and reimbursed by payers. While many clinicians could not implement every aspect of an Inclusive Health-driven care model, those interviewed provided a comprehensive picture of what is needed to meet individual patient needs. These include:
 - Sufficient time with and preparation for patient visits,
 - Training and empowerment of clinicians and practice staff,
 - Effective use of accommodations,
 - Use of partnerships and team models, and
 - Inclusive attitudes.
- **Lack of knowledge about the needs of people with I/DD limits adoption of Inclusive Health models.** A lack of medical training specific to the needs of people with I/DD as well as limited on-the-job training limits the number of providers who can competently serve this population. Payers also have a limited understanding of the health care needs of people with I/DD, which affects the adoption of payment models that provide needed flexibility, and consistent payments that enable clinicians to invest in accommodations and receive adequate reimbursement for their time.
- **Although existing billing codes offer reimbursement opportunities for services consistent with Inclusive Health, there are barriers to their use.** The coding analysis revealed a number of codes relevant to the elements of an Inclusive Health-driven care model. These codes, however, contain specific requirements for documentation that limit their use, along with other limiting factors, including clinician and entity awareness and the level of reimbursement. In addition, clinicians noted services that are not covered, such as administrative time, as well as concerns about additional audits triggered by use of higher-paying codes, and a hesitancy to subject patients to higher copays when optimizing coding.
- **Clinicians reported that existing coding options, coverage policies, and payment structures did not account for the costs of delivering Inclusive Health.** Clinicians often noted the codes' significant limitations in covering clinician time and lack of return on investment for time to implement these coding schemes. Clinicians indicated that the costs are at least twice the amount of reimbursement, and nearly all rely on other kinds of funding (like grants) to support their care for people with I/DD. In particular, current coding options do not account for needs related to infrastructure accommodations, which facilitate patient access and comfort and create welcoming provider settings.

- **VBP options offer opportunities for improvement, and there are examples in states and Medicare Advantage (MA) that are promising.** The coding analysis and interviews revealed the development of payment models better equipped to reimburse clinicians who serve the I/DD population and provide consistent payments and needed flexibility. These models, if scaled, could help to address current concerns about coding, coverage, and payment for services provided to people with I/DD.

KEY TAKEAWAYS

Clinicians identified key facilitators for implementing Inclusive Health-driven care models.

Lack of knowledge about the needs of people with I/DD limits adoption of Inclusive Health models.

Although existing billing codes offer reimbursement opportunities for services consistent with Inclusive Health, there are barriers to their use.

Clinicians reported that existing coding options, coverage policies, and payment structures did not account for the costs of delivering Inclusive Health.

VBP options offer opportunities for improvement, and there are examples in states and MA that are promising.

Based on our findings, we identified several recommendations for addressing barriers to Inclusive Health:

- **Cover additional services needed to achieve care models consistent with the principles of Inclusive Health.** This includes coverage for additional services, better options to cover structural accommodations, and changes to better support individuals with I/DD and their families accessing care.
- **Provide sufficient payments that account for the significant costs and flexibility needed to implement Inclusive Health-driven care models.** Increased fee-for-service (FFS) pricing needs to be coupled with more innovative options that improve infrastructure investments, provide flexible and predictable payments to clinicians, and incentivize enhanced integration of services. All changes in financing structures should be accompanied by concrete metrics in the form of quality measures that assess patient experiences and outcomes.
- **Reduce administrative burdens for clinicians and staff who serve individuals with I/DD.** Coding documentation, excessive payer reporting requirements, Supplemental Security Income (SSI) enrollment and documentation, as well as confusion about privacy requirements, hinder the adoption of care models. Adjusting, reducing, and simplifying these requirements will help clinicians to focus on what matters—patient care and forward-thinking investments to improve patient experience.
- **Increase training of clinicians and staff to enhance the workforce who can execute Inclusive Health-driven care models and increase education of payers to support provider and practice innovation.** To facilitate improved care models, education of both clinicians and payers is needed. Education is needed to encourage more clinicians and practices to provide care to patients with I/DD. Importantly, the workforce also needs to understand and acknowledge the persistent stigma and biases that prevent full realization of inclusive care models and respect for individual agency in health care decision making. Payers need to understand the necessity of higher, more flexible payments to meet the unique health care needs of this population.

Improvements that meet the principles of Inclusive Health are achievable with targeted actions that improve coverage and payment, reduce administrative burdens, and increase education and training. These improvements have the ability to impact the inequities individuals with I/DD experience and foster partnerships of clinicians, payers, and patients dedicated to addressing disparities through holistic, person-centered care models.

BACKGROUND AND APPROACH TO ANALYSIS

An estimated 6.4 million Americans have intellectual disabilities,¹ and as many as 10–16 million Americans have I/DD.² This significant cohort experiences disproportionate challenges in accessing health care, with evidence suggesting these individuals receive poorer care and lower rates of preventive screenings, have higher rates of complex chronic conditions, struggle to find clinicians with the requisite training and experience to accommodate their needs, and experience implicit and explicit biases that affect their quality of life.

Compounding these challenges are limitations clinicians—including those who most consistently treat individuals with I/DD—experience in providing care to this population. Clinicians report barriers to providing high-quality care due to limited time with patients, communication barriers, extra preparation and accommodations needed for visits, and lack of medical and staff training on how to care for people with I/DD. Many of the barriers experienced are attributable to significant gaps in the payments and needed funding for investments to provide patients with I/DD with tailored care.

Special Olympics has promoted the concept of Inclusive Health, which health care clinicians and practices can use to ensure equitable access to and full participation in high-quality services for people with I/DD.³ The principles of Inclusive Health point directly to addressing key challenges patients with I/DD face, as well as elements that clinicians and practices struggle to provide, including: (1) welcoming spaces ensuring that the physical environment is accessible, (2) communication that ensures both spoken and written communications are accessible to people of all literacy levels and provide supports for individuals, (3) awareness and training for staff and leaders about the barriers for people with I/DD and ways to overcome those barriers, and (4) sustainable and intentional inclusion of people with I/DD and their representative organizations in policy and systems as well as in care decisions.

This project was undertaken to evaluate the use and potential for coding mechanisms that would help to reduce barriers individuals with I/DD face when accessing health care and improve care models that uphold Inclusive Health principles. Through a detailed coding analysis, literature review, and interviews with 22 experts, the team arrived at key findings on the elements necessary for a holistic model of inclusive care; the gaps in coding, coverage, and payment that impact its implementation; and potential policy options to improve individuals' access to innovative inclusive care models, as well as payer and clinician uptake of these models.

Methods

The team conducted the environmental scan through three main workstreams, including an analysis of coding requirements and practices, targeted review of literature, and key informant interviews. Through these analyses and interviews, the team sought to provide insights on six core questions focused on how coding and payment improvements could facilitate improved access and efficacy of Inclusive Health care models. Key questions included the following:

- What have been the financial pain points for clinicians/practices in caring for the patient population with I/DD?
- What coding practices have clinicians/practices devised or adopted to reduce financial barriers (maximize economic benefits) to caring for people with I/DD (*i.e.*, coding for Inclusive Health)?
- What was the financial efficacy (increased revenue) of coding for Inclusive Health? What were the negative externalities of coding for Inclusive Health, such as increased out-of-pocket costs for patients?
- How (if at all) do the 2021 revisions to the evaluation and management (E/M) office visit coding documentation requirements change the need for or utility of coding for Inclusive Health?
- What are the prospects or limitations of coding for Inclusive Health to reduce barriers to care for people with I/DD?
 - Individuals covered by Medicaid versus Medicare versus commercial insurance.
 - Different states' Medicaid payment/reimbursement rates.
 - Shifts to VBP models.
- In light of the above, what should be the target markets for provider education about coding for Inclusive Health?

Workstream 1 – Coding Analysis

In Workstream 1, the team analyzed the coding requirements for E/M introduced in 2021 and explored codes for chronic care management, transitional management, and other services, as well as diagnostic coding options that may be used to gain reimbursement for care consistent with the Inclusive Health approach. The coding analysis examined procedure codes (*e.g.*, CPT® [Current Procedural Terminology] and HCPCS [Healthcare Common Procedure Coding System] codes) for services related to I/DD. In addition, the team reviewed Medicare, Medicaid managed care and other value-based arrangements. Findings from this workstream informed the interviews conducted in Workstream 3.

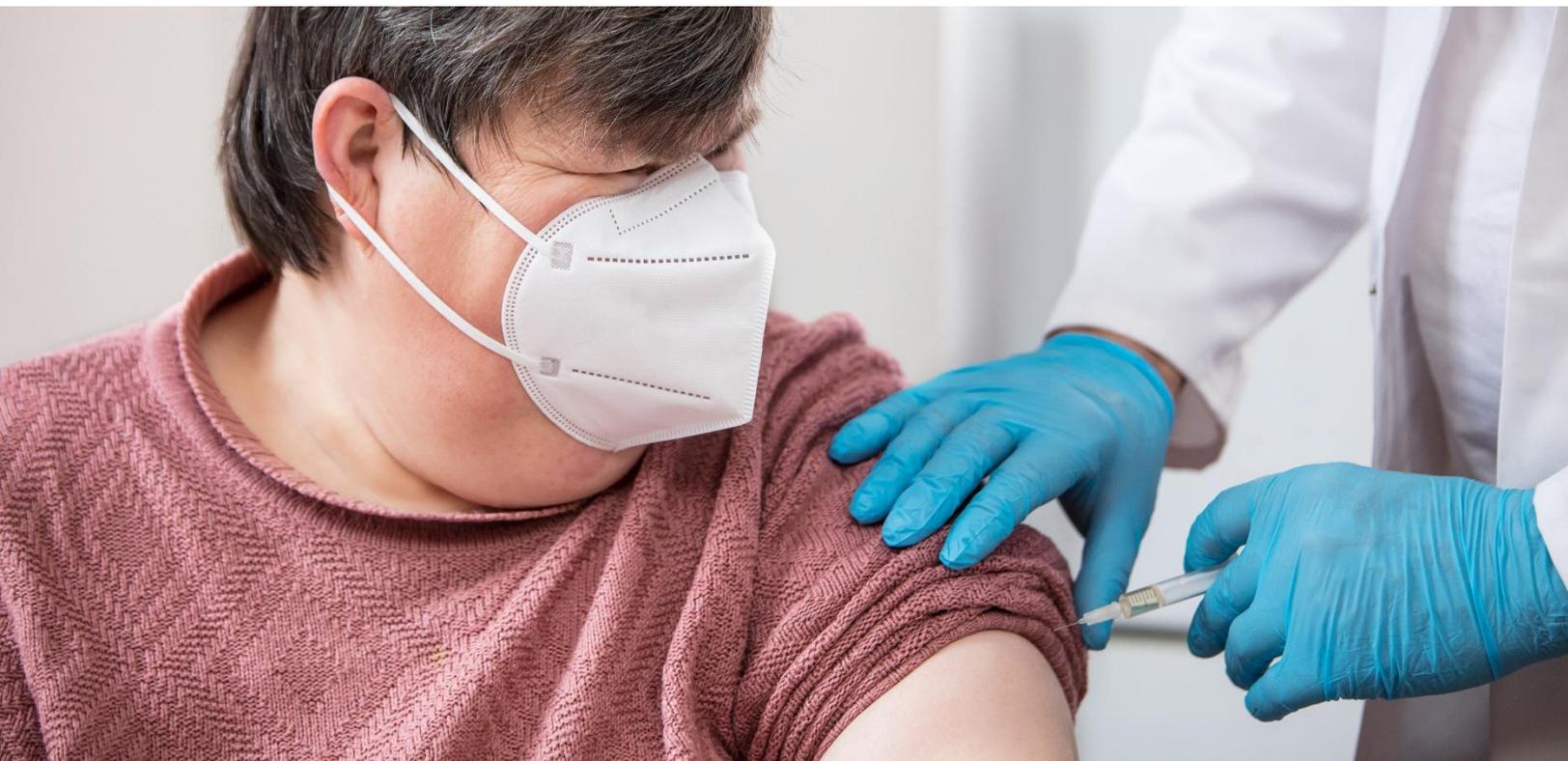
Workstream 2 – Literature Review

In Workstream 2, the team conducted a targeted review of peer-reviewed and gray literature addressing the financial issues clinicians and practices encounter when providing care for people with I/DD. The final literature review included 20 reports from diverse academic journals, think tanks, government provider resources, and organizations focused on individuals with I/DD.

Workstream 3 – Expert Interviews

In Workstream 3, key informants were interviewed to gather detailed information on the experiences of clinicians, practices, and other stakeholders on the use and limitations of existing codes. In addition to capturing current practices and financial experience, the team sought input on the prospects or limitations of coding for Inclusive Health to reduce barriers to care for people with I/DD. A total of 17, 30-minute interviews were conducted with 22 experts (nine clinicians and 13 additional non-clinician experts). Clinicians interviewed included those who provide care in small practices and as independent practitioners, those associated with larger hospital systems, children’s hospitals, and academic medical centers, as well as one federally qualified health center (FQHC). Clinician specialties included primary care, pediatrics, internal medicine, psychiatry, and dentistry. Other experts included payers, patient advocates, and government officials.

Questions asked during the interviews were tailored to apply to clinicians as well as other experts in I/DD care. From each interview, the team sought to understand the participant’s view of Inclusive Health, including care model elements necessary to achieve Inclusive Health principles; practices currently in place to meet the needs of patients with I/DD; opportunities and barriers of current coding, coverage, and payment mechanisms for clinicians treating this population; and systemic, educational, and policy changes needed to better facilitate holistic, inclusive care models.



FINDINGS

This section provides key findings distilled from the coding analysis, literature review, and expert interviews.

Care Model Elements and Barriers Impacting Their Use

Clinicians, other experts, and the review of literature revealed elements critical to a care model that incorporates Inclusive Health principles, including accessible, welcoming spaces; effective communication between clinicians, patients, and their caregivers; comprehensive training for staff to address key barriers individuals with I/DD face in accessing health care services; coordination with non-clinical service providers; and intentional and systematic inclusion of people with I/DD in their care. To achieve these principles, the team distilled expert insights into the following care model elements: sufficient time with patients, training and empowerment, accommodations, partnerships and team models, attitudes consistent with inclusion and respect, and other resources and supports.

Sufficient Time with Patients

The care model element most cited by clinician interviewees and apparent from the literature review was sufficient time for clinicians to spend with patients and in preparation for their care. Across the board, clinicians noted that they need additional time and more visits to provide quality care to this population. More time with patients allows clinicians to establish trust and thoroughly understand a patient's needs, provides time for patients to acclimate to the practice setting, and makes it possible to offer desensitization techniques and other appropriate accommodations.

More time also affords clinicians and their staff the ability to deploy varied strategies to support effective communication with patients and their caregivers and to understand patient needs. Importantly, more time allows for the implementation of supported decision-making processes to ensure the patient's preferences are prioritized and agency respected. Clinicians also cited addressing lack of time with patients as crucial to allowing for the design and deployment of flexible care tailored to the patient, and for coordination with others serving the patient, including those providing home- and community-based services (HCBS), durable medical equipment (DME) suppliers, home health agencies, and other service providers.



CARE MODEL ELEMENTS

- Sufficient Time with Patients
- Training and Empowerment
- Accommodations
- Partnerships and Team Models
- Inclusive Attitudes
- Other Resources and Supports

Training and Empowerment

Clinicians and other experts cited training and empowerment in two contexts: training to ensure competent staff to support visits with patients and ensure safe and effective encounters, and more comprehensive medical training on I/DD to increase the number of competent clinicians who understand the unique needs of this patient population. With the former, clinicians explained they need staff that are prepared for the stressful situations that can occur during interactions with patients and the need to empower staff to resolve these situations safely, even where it results in delays in the visit. The ability to handle such situations requires training in tailored communication strategies.

Accommodations

Accommodations help ensure people with I/DD can successfully access health care services and experience a welcoming environment when receiving care. Clinicians noted several types of accommodations they use to facilitate a more inclusive practice, including physical and built environment, equipment, workflows, and specific treatments. Physical and built environment accommodations include those physical elements needed to meet Americans with Disabilities Act (ADA) requirements, such as clearance for wheelchairs and buildings designed to be accessible for individuals who use wheelchairs or individuals with more limited mobility. Other physical elements include those needed to facilitate linguistic accessibility and designs to ensure the safety of patients and staff. Beyond the basics, clinicians also cited elements to make patients more comfortable, including dimmable lights, sound buffers, quiet rooms, and larger exam rooms capable of accommodating support personnel. Equipment needs include Hoyer lifts, accessible scales, swings for occupational therapy, head rests for exams in wheelchairs, and dental-specific chairs and equipment. For workflows, clinicians discussed the need for specialized intake processes and desensitization sessions, including flexibility on telehealth, digital options, and care exams, as well as using private rooms for certain laboratory procedures, such as blood draws.

Partnerships and Team Models

Clinicians and other experts explained how they use team-based models and partnerships with other providers and community-based organizations (CBOs) to meet the needs of I/DD patients. Clinicians spoke to the value of team-based approaches to plan for patient care and close coordination among specialties to ensure consistent and coordinated care. They described instances in which they collaborated with community members to co-design clinic spaces and care processes, as well as with HCBS providers and other CBOs to ensure patient care needs were met outside of the clinical setting. One clinician pointed to the potential efficacy of a legal service agency that could partner with providers for advanced care planning and care transitions, as well as other organizations that could coordinate transitions from pediatric to adult services and caregiver-to-caregiver supports. Other collaboration suggestions included those with DME suppliers, social workers, dieticians, and patient educators.

Inclusive Attitudes

A critical component overlaid with other care model pieces is the need for clinicians and staff to have inclusive attitudes that help facilitate effective communication with patients and allow for holistic care driven by patients. Clinicians and experts explained the need for clinicians to presume ability and respect patients, including through utilization of supported and shared decision-making processes with patients and caregivers. Clinicians and other experts spoke to needed improvements to facilitate equitable care, including in assessment of the need for preventative services and the need for appreciation of the patient's quality of life. This need is supported by the literature, which suggests that stigma remains evident in clinical care for people with I/DD, with many physicians reporting that people with significant disabilities have worse quality of life than those without, that they are not actively welcoming patients with disabilities into their practices, and that they often communicate with persons other than the patient when treating individuals with disabilities, including I/DD.^{4,5,6}

Other Resources and Supports

Clinicians and other experts pointed to other care model elements that would aid in promoting Inclusive Health if they were consistently available. These included actions to address social drivers of health, such as transportation needs, and providing support and resources to patients and caregivers, such as navigation of services or help understanding out-of-pocket expenses.

Coding Opportunities in Fee-For-Service and Value Based Payment

The coding analysis revealed an increasing number of opportunities for fee-for-service (FFS) reimbursement for care consistent with Inclusive Health. Still, the proliferation of codes, with requirements that may limit uptake, presents a barrier to coding for Inclusive Health. VBP arrangements to address care for patients with I/DD can expand the types of services covered and offer the potential to support adoption of Inclusive Health care models at scale.

Fee-For-Service

Recent changes in coding from the Centers for Medicare & Medicaid Services (CMS) expand the opportunities for reimbursement of services consistent with Inclusive Health in FFS care. CPT and HCPCS codes for services consistent with Inclusive Health include codes that reimburse clinician time, non-clinician time, coordination with specialists, physical accommodations, and addressing social needs (see Table 1).

E/M coding changes in 2021 shifted to a time-based model designed to capture additional resources required for medical decision making for patients with more complex needs. These changes simplified documentation that used to rely on documentation of history and physical examination and allow for more time to be allocated to addressing specific patient needs. Newer codes also provide opportunities to document health related social needs, including the services that community health workers and peer navigators provide. CMS has also changed the requirements for supervision of behavioral health staff and allowed a wider range of mental health providers to independently treat people with Medicare. Additional coding changes in Medicare FFS as proposed in the 2025 Physician Fee Schedule (PFS) show promise around better coding for clinician time with simplified requirements on complexity and coverage of additional services in behavioral health and caregiver training.

Changes in Medicare coding and reimbursement practices are widely adopted in Medicaid and commercial settings. Still, the proliferation of codes for specific services, each with its own documentation requirements, creates uptake challenges. Using these varied codes requires a sophisticated approach to staffing, clinical care, and billing, as well as time to ensure that the billing is correct. CMS auditors look carefully to determine whether codes are billed accurately, and errors in billing can have consequences for a practice's ability to continue to receive Medicare reimbursement. Thus, the complexity of the codes and documentation requirements, as well as the threat of an audit, limits the use of the codes. And, while newer codes now cover many additional non-clinical services, they still do not cover administrative time needed for billing or other administrative duties.



Table 1. Billing Codes Consistent with Inclusive Health

<p>Clinician Time</p>	<ul style="list-style-type: none"> • Evaluation and Management (E/M) • Care management • Transitional care management (from inpatient to other settings) • Case management and targeted case management • Behavioral health integration (BHI) in the psychiatric collaborative care model (CoCM) • Psychiatric diagnostic evaluation services and psychotherapy services (inclusive of interactive complexity) • Crisis services • Telehealth, virtual communications, and remote patient monitoring • Behavior assessment and intervention • School-based services (e.g., individualized education programs [IEP]) • Preadmission screening and resident review (PASRR) • Alcohol and substance use services
<p>Non-Clinician Time</p>	<ul style="list-style-type: none"> • BHI in the psychiatric CoCM • Incident-to • Chronic care management (including principal care management) • Transitional care management • Translation/interpretation services
<p>Coordination with Specialists</p>	<ul style="list-style-type: none"> • E/M • Care management • Transitional care management • BHI in the psychiatric CoCM
<p>Accommodations</p>	<ul style="list-style-type: none"> • Durable Medical Equipment (DME) • Non-emergency medical transportation (NEMT) • Private duty nursing and other general nursing services • Personal care services • Respite care • Wheelchair management • Assistive technology and assistive technology assessment • Community/work reintegration • Home health services • Outpatient physician and occupational therapy services
<p>Addressing Social Needs</p>	<ul style="list-style-type: none"> • E/M • Social determinants of health assessment • Community Health Integration (CHI) • Principal illness navigation (PIN)

Value-Based Payment

VBP reforms provide an opportunity to incentivize improvements in care and efficiency for individuals with I/DD. Increasingly, MA and Medicaid managed care contracts are available that focus on people with I/DD and offer a broader range of services than are available in FFS. MA plans can offer expanded services or supplemental benefits that can support health outcomes for members (see Table 2). In Medicaid, states are expanding payment for care consistent with Inclusive Health through state plan amendments, waivers, and managed care. Currently, ten states have their own I/DD specific VBP models: Arkansas, Arizona, Iowa, Kansas, Michigan, North Carolina, New York, Tennessee, Texas, and Wisconsin. Medicaid MCOs can also provide extra benefits, called Value-Added Benefits, to their members (Table 2). While a few states have I/DD-focused Medicaid MCOs, these plans are too small or too new to offer generalizable lessons about the best ways for structuring payments to providers.

Table 2. Examples of Added Benefits in Medicare and Medicaid Managed Care

Supplemental Benefits in Medicare Advantage	Value-Added Benefits in Medicaid
<ul style="list-style-type: none"> • Emergency response systems • Fitness programs • Social and recreational programs • Structural home modifications • Hearing and vision services • Non-emergency transportation • Healthy meal programs (including personal debit card) • Personal care assistance • Over-the-counter medication stipend • Telehealth services 	<ul style="list-style-type: none"> • Gift cards for health screenings and visits • Workforce development: Childcare, interview prep, transportation vouchers • \$500 in housing aid to help pay for utilities, rent, & more • GED advisor coaching, prep, and testing for members ages 18 and older who want to get their diploma • 24/7 telehealth visits • Online housing, employment, and money management skills training • Community Connectors who work with case managers to provide members with support/education services • Self-care app to help reduce anxiety and depression • Smartphone with data, talk, and unlimited text • Member empowerment supports, including housing and food assistance for homeless/at-risk and food insecure members • Home delivered meals • \$1,000 college and trade school scholarships

Barriers to Coding for Inclusive Health

Despite clinician knowledge of and work to achieve care models consistent with the principles of Inclusive Health, and some opportunities in coding consistent with those goals, there are also significant barriers. These barriers help to explain the gaps between care and payment available today and the improved state of care delivery possible for the I/DD population.

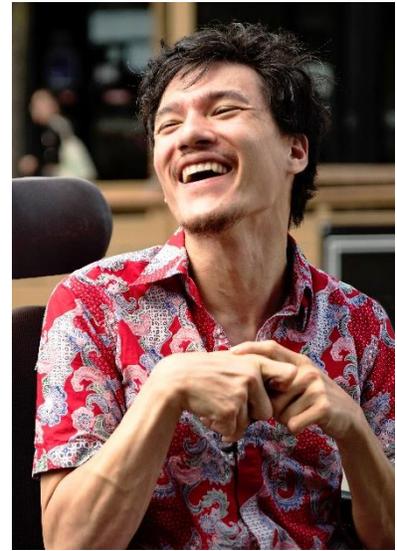
Time

Clinicians reported capacity and financial considerations as the core barriers to achieving sufficient time with patients. To effectively meet the needs of multiple patients, both those with I/DD and others, clinicians experience pressure to efficiently discharge patient visits. However, clinicians interviewed pointed more to financial considerations as a limiting factor affecting what they could do, because some clinician time is uncompensated or under-reimbursed, or payment rates are not worth the extensive staff time required to determine how to bill for such activities. Similarly, surveys of clinicians support the idea that financial considerations limit time with patients with I/DD.^{7,8}

Despite some existing coding opportunities through E/M, as well as other codes to capture time spent by clinicians outside of patient visits, most clinicians consulted did not see coding as the best solution to adequately compensate for the time spent delivering care to patients with I/DD. Importantly, while coding, coverage, and payment considerations served as a limiting factor impacting time clinicians could spend with patients, every clinician consulted articulated instances where they served patients despite time being uncompensated because of the importance of meeting the patient's needs.

Coverage and Payment

No practice consulted fully finances its Inclusive Health-driven care model through the use of traditional FFS reimbursement, and FQHC prospective payments are similarly underpriced. These limitations speak to significant limitations in coverage for services across different payers, as well as payment that underprices clinician time and resources used to serve the I/DD population.



BARRIERS TO INCLUSIVE HEALTH

- Time
- Coverage and Payment
- Infrastructure and Accommodations
- Workforce and Training

Coding and Billing

Practices reported limited FFS codes to adequately account for time, including E/M coding options and G-modifier codes. Practices interviewed rarely billed codes for non-visit time, including care coordination, care management, and collaborative care, but some practices used codes for chronic care and post-discharge transition, as well as oversight of Medicaid care plans. Other coding limitations include limitations on billing incident-to other providers. Additionally, clinicians reported that structural barriers limit new coding options, given the lengthy process required to create new CPT codes and the length of time payers take to adopt new codes for use.

Costs and tradeoffs associated with implementing new codes seems to limit their use, along with significant administrative burdens in meeting documentation requirements for use of certain codes. Practices reported inertia in willingness to update code sets for electronic health records; low volume of patients with I/DD, which discourages training of billing staff otherwise unfamiliar with applicable code sets; and a lack of templates and guidance on optimal coding.

Inadequate Coverage and Payment

Clinicians reported that the gap between FFS revenue at current rates and the actual “run rate” of input costs ranges from two to three times the revenue. Payment to cover upfront investments in infrastructure and staff training would equal another two to three times their current revenues. These payment challenges force reliance on grants, subsidies from other departments, and philanthropic sources, all of which may still not cover costs for the practice.

Inadequate coverage for specific services contributes to this challenge. Clinicians and other experts reported difficulties when time-based reimbursement does not apply to all necessary services. For example, providers of genetic counseling require the skills and expertise of multiple clinicians, some of whom are restricted from billing for service provided during the same encounter—even when that would be more efficient and beneficial for the patient. Clinicians and other experts also reported more limited coverage and payment for certain therapy services and care coordination activities.

Though some coding options address additional clinician time before, during, and after the visit, ultimately, practices concluded that the fee amounts for certain codes were not high enough to justify creating new billing and documentation processes. One interviewee also flagged that, even where optimal codes are available in the E/M coding sets, use of higher-paid complex care codes can put providers at risk (or the perception of risk) of auditing by payers or regulators, thereby dampening the use of those codes.

Experts also pointed to a lack of meaningful risk adjustment methods to account for patient complexity as a contributing factor to inadequate payment rates.

Patient Cost Sharing

Several clinicians and experts pointed to externalities, such as increased copays and out-of-pocket costs for patients, as reasons for limiting the use of more optimal coding to capture clinician time and expense for providing care. They also pointed to structural limitations, like the statutory coverage and payment requirements in Medicare Part B, which prevent waiving of cost sharing. Clinicians interviewed were reticent to use codes that they knew would negatively affect patient cost sharing.

Infrastructure and Accommodations

Clinicians and other experts reported difficulties in implementing desired infrastructure and accommodations to support practices. FFS billing does not cover upfront investments in infrastructure and equipment or built environment needs for practices. As a result, clinicians must find ways to finance upfront investments to meet legally required accommodations and additional accommodations to enhance patient comfort and accessibility in their practices. Clinicians also reported difficulty in retrofitting older buildings to meet accommodations, including both physical accommodations and other types of accommodations developed to improve patient experience. Though interviewees did not discuss these factors, the literature on accommodations to serve individuals with disabilities more broadly notes that clinicians may be unaware of necessary accommodations for patients, as well as concerned about the return on investment to implement certain accommodations for smaller percentages of their patients.⁹

Workforce and Training

For clinician training, the literature and interviews suggest that there is little to no medical training specifically focused on care for the I/DD population. This type of training is needed, as surveys suggest on-the-job experience alone does not increase clinician confidence in meeting patient needs.¹⁰

Clinicians and experts focused on the need for training of administrative and support staff to help patients feel more comfortable and ensure the safety of the practice outside of the clinician encounter. However, several clinicians also noted the workforce limitations in hiring and retaining qualified office staff.

Importantly, some payers we interviewed were unfamiliar with key care elements needed to facilitate Inclusive Health-driven models, as well as an understanding of the unique challenges facing individuals with I/DD and their caregivers in accessing care. Training on the payer role in meeting care model needs is also necessary to ensure the adoption of Inclusive Health principles.

Opportunities Identified by Stakeholders

Experts interviewed identified several opportunities to facilitate the uptake of Inclusive Health-driven models. These changes would increase coverage and payment for services and, therefore, increase their use. Improved and increased use of VBP models might also improve the quality of care provided to individuals with I/DD.

Beyond coverage and payment, stakeholders recommended more systematic policy options to ensure payment for services is integrated across different payers and is properly financed. Lastly, stakeholders discussed the opportunity to better train clinicians and other personnel on interacting with individuals who have I/DD and address stigmas that continue to affect this population's access to high-quality health care.

Coverage

Clinicians identified several opportunities for increased coverage to better support Inclusive Health. One example they pointed to was coverage that would allow providers to coordinate care with each other, including inpatient and primary care teams, genetic counselors, and other specialists. They also expressed interest in developing coding—beyond incident-to—that allows multiple clinicians to join a visit with a patient. Finally, clinicians suggested bundled payments for routine screenings for mental and dental health issues.

Clinicians and other experts discussed the utility of additional coverage for administrative activities, including helping patients to assess eligibility for and apply for public benefits, as well as for staff time spent in preparation for a visit.

Some of the identified policy options were specific to patient and caregiver incentives. Several experts highlighted the possible benefits of eliminating copays for non-visit-based services to address a key negative externality to more accurately bill for time with patients. There could also be benefits to offering additional incentives for patients to seek routine primary and preventive care, screenings, and intervention services. Lastly, some states pay family caregivers for their work effort—a model which, if expanded, could address barriers to accessing care.

Payment

Higher payments and improvements to payment models were the opportunities most mentioned as avenues to achieving Inclusive Health-driven models. To help practices address the deficit between their run rate and revenue, clinicians and experts cited the need for higher payment rates for existing codes. For example, more consistent use of Z-codes and other modifiers for complex care (G2211) could be incentivized through further increases in reimbursement. Health plans and public payers could also offer infrastructure payments to providers to help finance needed accommodations.

In conjunction with improved coding and payment mechanisms, experts also spoke to the need to lower administrative burdens on clinicians treating individuals with I/DD. They mentioned the need to address unpaid time spent on paperwork, eliminate prior authorizations, and alter reporting requirements, which currently make accepting payment from government payers more difficult than resourcing care in alternative ways.

A number of experts acknowledged the limitations in FFS and recommended more significant changes to payment models, which would provide greater flexibility and clinician control over care model elements. One practice was able to negotiate a per member per month (PMPM) payment arrangement with a state Medicaid program, allowing for capitation that covered the care needs of more complex patients and better enabled the practice to cover investments in resources that benefited their whole patient population and maintain a foreseeable revenue. Experts noted that VBP models also present an opportunity for clinicians to be rewarded for improved outcomes for patients with I/DD while sharing in risks, thereby incentivizing high-quality care and comprehensive care management.

Other Policy Changes

Experts mentioned other policy changes that would have systemic effects on financing care and aligning incentives for clinicians and payers.

Savings in the Right Pocket

One dynamic mentioned several times was the “savings in the wrong pocket” problem, which describes instances where efficiencies or improved services in one sector may result in savings to another sector. Given how siloed delivery of care to individuals with I/DD is across different payers for services, including medical (separated by inpatient, outpatient, and long-term care between Medicare and Medicaid), dental, behavioral, and HCBS, these perverse incentives can affect the willingness of payers to invest in higher payments for one set of services when they cannot recoup those investments through savings that appear in another sector.

Considering a significant number of individuals with I/DD are dually eligible for Medicare and Medicaid,¹¹ addressing siloes between Medicare and Medicaid is critical. Interview subjects mentioned needs for improvements to requirements for dual-eligible special needs plans (D-SNPs), which are required to more closely participate in care coordination on Medicaid benefits and share in defined roles and responsibilities with states through required state Medicaid agency contracts (SMACs). There are also opportunities for additional changes to amend Medicare and Medicaid statutory authorities to allow for fully integrated care.

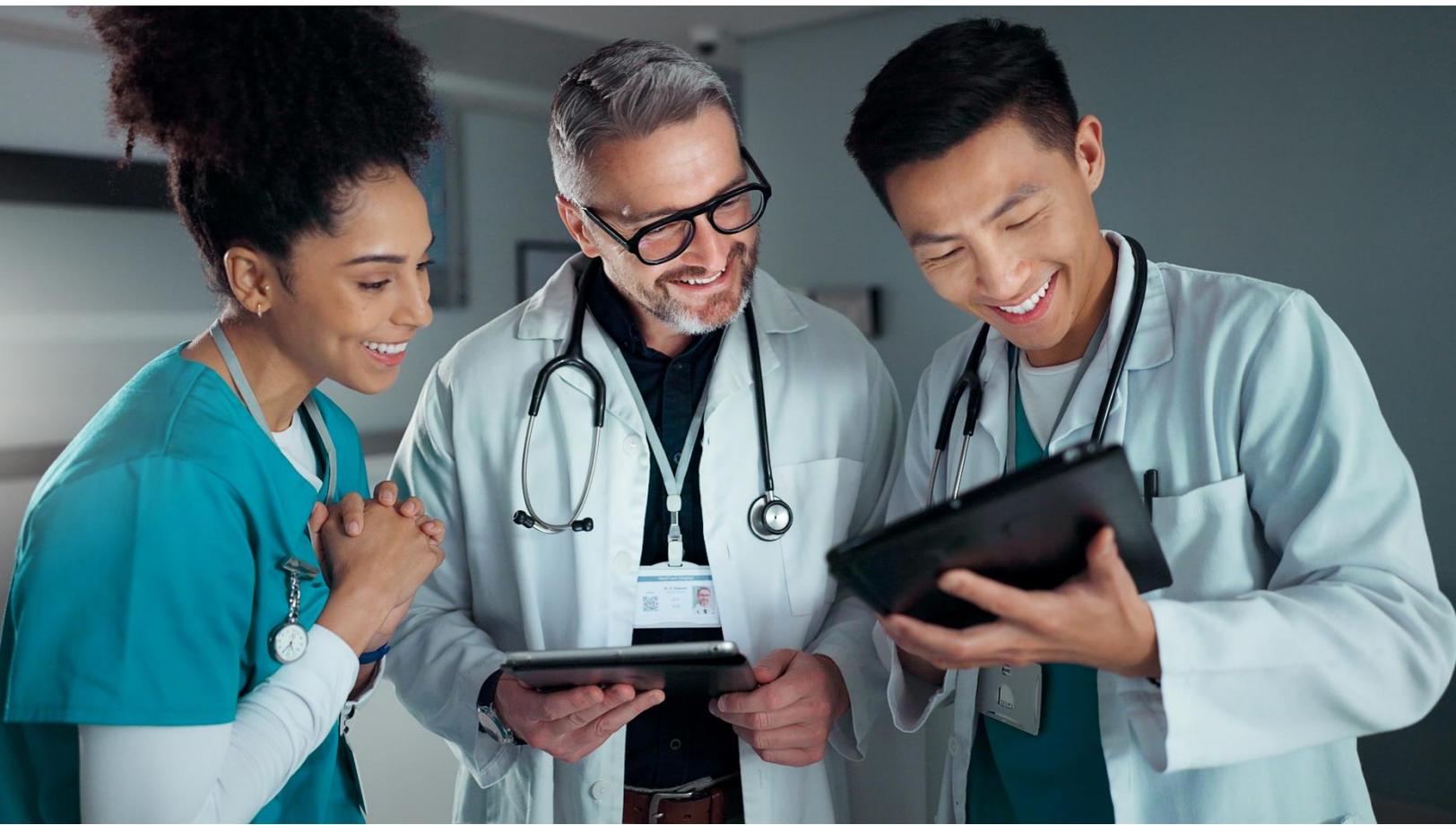
Public Financing

Clinicians and other experts also mentioned changes to public financing that would have trickle down effects for practices and improve access for patients. Several experts mentioned that enhanced Medicaid financing could help to solve several limitations in payment directly to clinicians in FFS as well as reduce pressure on managed care organizations (MCOs) to employ stringent utilization management techniques. Better financing could also facilitate more I/DD carve-ins for HCBS and other services, providing more streamlined care delivery. Experts also discussed public financing as a means of addressing key barriers related to social determinants of health, particularly transportation.

Training and Workforce

Nearly all clinicians and many experts with whom we consulted discussed the need for enhanced clinician training to meet the care model elements for Inclusive Health and to reduce persisting stigmas about people with I/DD that affect access to high-quality care. Clinicians and experts also pointed to the need for a more capable workforce, with capacity to meet the needs of patients with I/DD. For clinicians and other staff, basic training on I/DD can lower anxiety with and hesitancy in communicating with patients, providing accommodations, and building trust directly through relationships with patients. Training in trauma-informed care can help both clinicians and patients feel more comfortable in care settings. Some clinicians mentioned models for specialized clinics that could extend training opportunities beyond medical schools.

On the administrative side, clinicians and experts mentioned the need for more technical support for clinicians and practices to assist patients in applications for public benefits, as well as improved data collection on how people with I/DD are receiving care. Transition planning (for when caregivers die or are no longer able to provide needed care) is also a critical area for increased provider awareness and training. Lastly, centralized databases of resources would be helpful to support families and clinicians and raise awareness about existing options for care, outside of resources they may receive in medical practice settings. Interviewees indicated that a critical piece of training and enhancing resources involves addressing persistent stigmas and biases. The reality is that prejudgments about patients with I/DD and their quality of life, as well as underestimations of their ability to understand and lack of respect for their agency hinder holistic, patient-driven care.



KEY TAKEAWAYS

Overall, the interviews and analysis provided details on how to structure care models to meet the needs of individuals with I/DD, as well as opportunities to code for services and utilize VBP arrangements.

Clinicians identified key facilitators for implementing Inclusive Health-driven care models. Clinicians interviewed have applied a number of strategies to improve care for individuals with I/DD and noted core care model elements that could be better utilized across the board and reimbursed by payers. Though many clinicians said they cannot yet implement every aspect of an Inclusive Health-driven care model, those interviewed provided a comprehensive picture of what is needed to meet individual patient needs, including:

- Sufficient time with and preparation for patient visits,
- Training and empowerment of clinicians and practice staff,
- Effective use of accommodations,
- Use of partnerships and team models, and
- Inclusive attitudes.

Lack of knowledge about the needs of people with I/DD limits adoption of Inclusive Health models. A lack of medical training specific to the needs of people with I/DD, as well as limited on-the-job training, limits the number of providers who can competently serve this population. Payers also are limited in their understanding of care needs, which affects the adoption of payment models that provide needed flexibility and consistent payments that enable clinicians to invest in accommodations and adequately reimburse them for their time.

Although existing billing codes offer reimbursement opportunities for services consistent with Inclusive Health, there are barriers to their use. The coding analysis revealed a number of codes relevant to the elements of an Inclusive Health-driven care model. These codes, however, contain specific requirements for documentation that limit their use, along with other limiting factors, including clinician and entity awareness and the level of reimbursement. In addition, clinicians noted services that are not covered, such as administrative time, as well as concerns about additional audits triggered by use of higher-paying codes, and a hesitancy to subject patients to higher copays when optimizing coding.

Clinicians reported that existing coding options, coverage policies, and payment structures did not account for the costs of delivering Inclusive Health. Clinicians often noted the codes' significant limitations in covering clinician time and lack of return on investment for time to implement these coding practices. Clinicians reported that the costs were at least twice the amount of current reimbursement and nearly all relied on other kinds of funding (like grants) to support their care for people with I/DD. In particular, current coding options failed to account for needs in infrastructure accommodations, which facilitated patient access and comfort in welcoming provider settings.

VBP options offer opportunities for improvement, and there are examples in states and MA that are promising. The coding analysis and interviews revealed the development of payment models better designed to reimburse clinicians who serve the I/DD population and provide consistent payments and needed flexibility. These models, if scaled, could help to address current concerns with coding, coverage, and payment for services for people with I/DD.

POTENTIAL SOLUTIONS

With the findings from the coding analysis and literature review, as well as the breadth of insights provided by clinicians, payers, government officials, and patient advocates, the team developed four focus areas of potential solutions to improve coding for Inclusive Health.

Cover additional services needed to achieve care models consistent with principles of Inclusive Health.

Coverage for additional services and investments is needed across payers to ensure that clinician time is compensated. This includes coverage for services related to clinician planning and clinician-to-clinician consultation about patient care, as well as visits involving multiple clinicians simultaneously to make efficient use of patient and caregiver time. Additional consideration is needed on coverage for innovative therapeutic techniques that would benefit individuals with I/DD.

Better options to cover structural accommodations are also needed. Practices often cannot support the upfront investments needed to make their spaces more welcoming and accessible for individuals with I/DD and struggle to meet basic components required for physical accessibility. Though recent regulatory requirements for updates to accommodations^{12,13} may push some payers to more closely consider investments for practices, additional options are needed.

Enhancements in coverage for clinicians and practices must be accompanied by changes that better support the ability of patients and families to access care. This includes additional resources for families to understand the availability of services in the community, as well as improvements that allow more caregivers to be reimbursed for their time in providing support to patients with I/DD. Patient incentives are also useful in facilitating Inclusive Health-driven care models. Tiering copays or exploring specific carve outs or models that eliminate copays for patients would allow clinicians to feel more comfortable coding for a broader range of services.



Table 3. Potential Solutions to Address Barriers

Topic	Potential Solution
<p>Cover Additional Services</p> <p>What is not covered in existing codes?</p>	<ul style="list-style-type: none"> • Cover time for visit planning and clinician-to-clinician consultations. • Cover for accommodations that are about additional time (rather than physical accommodations). • Cover the cost of caregivers' time. • Eliminate cost sharing for preventive visits and non-visit-based activities, which, for Medicare, would require statutory changes or otherwise giving CMS explicit authority to waive cost sharing.
<p>Provide Sufficient Payment</p> <p>What does optimal reimbursement structure to facilitate inclusive care model look like?</p>	<ul style="list-style-type: none"> • Increase FFS payment rates, including significant price increases (at least double) for common, relevant codes, including time-based E/M services, care management, modifier G2211, and care transitions. • Enact statutory changes to create two Medicare physician fee schedules—one for E/M services, another for procedures—to remove the budget neutrality constraints on raising prices for E/M services. • Provide states with incentives to integrate medical and HCBS financing and services in their Medicaid managed care programs, coupled with accountability for patient-reported outcome measures, including measures on access and experience of care. • Transition from purely FFS to at least partial PMPM payments to allow revenue predictability, compensate for unreimbursed activities, and create flexibility to tailor care. • Offer payments for infrastructure investments based on known best practices. • Require D-SNP plans to progress upward to the fully integrated tier within no less than ten years of their first Medicare contract. • Link new financing structures and higher payment levels to patient outcomes through VBP.
<p>Reduce Administrative Burdens</p> <p>What changes are needed to ease clinician burdens?</p>	<ul style="list-style-type: none"> • Reduce documentation burden for certain billing codes such as care management. • Reduce payer reporting requirements, particularly on process-related quality measures, to give health plans and providers more flexibility to focus on individual patients' needs, goals, and outcomes. • Develop common use cases of information sharing for care coordination and formal legal guidance to demystify HIPAA requirements. • Reduce SSI documentation requirements.

<p>Increase Training and Education</p> <p>What type of training for whom?</p>	<ul style="list-style-type: none"> • Educate payers on key elements of inclusive care models and ways to better support practices financially. • Educate clinicians and care team members who do not currently focus on serving people with I/DD on key elements of inclusive care models, for example, through Special Olympics’ plans to develop a self-audit tool for practices. • Address stigma and bias in clinical culture broadly. • Educate clinical organizations on FFS billing opportunities after successful implementation of the payment recommendations above.
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Provide sufficient payments that account for the significant costs and the flexibility needed to implement Inclusive Health-driven care models.

In addition to coverage for more services, changes are needed to increase reimbursement to clinicians who serve individuals with I/DD to account for gaps in revenue and run rate. In FFS, this could include price increases for relevant codes, but policymakers also need to take account for limitations, like the budget neutrality requirements in the Medicare PFS, which limit the feasibility of increasing FFS pricing as a standalone solution to account for payment gaps.

Another option to improve payment sufficiency includes front-end infrastructure payments that would allow practices to invest in resources that meet best practices for care.

While most clinicians interviewed spoke to the utility of increased pricing in FFS, none touted FFS as the ultimate payment system to meet Inclusive Health-driven care model needs. Instead, they focused on the need for flexible payment mechanisms to encompass a range of services and provide predictable payments that cover practice resources and time. Transitioning from purely FFS to at least partial PMPM payments could help to accomplish those goals.

States could also be incentivized to integrate medical and HCBS financing and services in managed care to help solve the “savings in the wrong pocket” problem. Additionally, increased requirements for D-SNP plans to progress upward toward the fully integrated tier within no less than ten years of their first Medicare contract could aid in the transition to more fully integrated plan options for dual eligible individuals.

Importantly, any changes to existing financing structures and innovations in VBP models should couple higher payment with greater accountability through quality measurement. This could be achieved through the use of patient-reported outcome measures on access and experience of care, and other measures focused on assessing improved patient outcomes.

Reduce administrative burdens for clinicians and staff who serve individuals with I/DD.

Clinicians consistently raised concerns about administrative burdens that affected their ability to achieve optimal reimbursement for their care models in treating individuals with I/DD. To allow

clinicians and practices to take advantage of existing and future codes that fill the revenue run rate gap, the documentation burden for billing certain codes needs to be decreased. Without further action, clinicians and practices will continue to utilize a cost-benefit analysis that works against instituting new, complicated coding structures to increase reimbursement.

Excessive payer reporting requirements also affect clinicians and practices, especially when the requirements are process-oriented rather than substantively evaluating clinical quality of care. Reducing payer reporting requirements could give both health plans and providers more flexibility to focus on patient care, rather than checking boxes with no link to improved patient experience or outcomes. Similarly, reducing and simplifying documentation requirements for SSI could remove a process-based difficulty for clinicians without placing patients at risk of lost benefits.

Another opportunity to reduce administrative burden is to clarify privacy requirements to facilitate effective care coordination. Further guidance could help clinicians and practices to better focus on patient care needs and provide flexibility to innovate in providing more integrated care.

Increase training of clinicians and staff to enhance the workforce who can execute Inclusive Health-driven care models and increase education of payers to support provider and practice innovation.

To facilitate improved care models, education of both clinicians and payers is needed. Payers need to better understand the significant gaps clinicians experience in accounting for services not covered or inadequately reimbursed and become familiar with Inclusive Health-driven care model elements. With this foundation, payers can be prepared to better support practices financially, both through appropriate rate setting and innovation into flexible and foreseeable payments.

For clinicians who provide care to a limited number of people with I/DD, there is a base level education needed so they can understand best practices to meet the unique needs of people with I/DD, and be incentivized to adopt inclusive care models. Special Olympics' role in developing tools that allow practices to self-evaluate could serve to assist in this education. After clinicians are more educated on care models, then training on FFS billing opportunities would make sense as a next step to help them in optimizing reimbursement.

Critical to the education of payers, clinicians, and the larger public is information about the persistent and unique challenges individuals with I/DD face in accessing care, and in their experiences with providers and others who stigmatize this population. Stakeholders responsible for caring for individuals with I/DD need to consistently respect the individual's agency over their health care decision making, their supported decision-making structure, and their rights equal to others who access the health care system.

CONCLUSION

At present, significant barriers prevent clinicians from optimizing Inclusive Health-driven care models to serve people with I/DD and there are barriers that continue to impact people with I/DD and their access to high-quality care. The analyses undertaken for this report reveal a patchwork of options to address inadequate reimbursement for clinicians and begin a transition toward VBP arrangements that will better facilitate and incentivize improvements in care. Further, interviews with clinicians and other experts revealed knowledge of and some use of care elements that would improve care for individuals with I/DD. However, despite some progress, key barriers in accounting for necessary time with patients, providing coverage and payment, addressing infrastructure and accommodation limitations, and building a robust and well-trained workforce to serve people with I/DD remain.

Changes that can cover additional services and resources needed to implement care models, as well as provide sufficient payments through FFS updates, Medicaid structural reforms, and innovative VBP arrangements, are needed to take Inclusive Health-driven care models from possibility to reality. Moreover, targeted policies that can address clinician and practice administrative burdens can allow for improved care coordination and bridge the gap between code set availability and clinician adoption. Lastly, it is critical that educational efforts to build a competent and capable clinician and support staff workforce accompany improvements in coding, coverage, and payment. At the end of the day, more clinicians are needed to serve individuals with I/DD, and without education that systematically addresses stigmas and biases against this population, improvements in inclusive care will be limited. In tandem, payers need education to better understand the needs of people with I/DD and implement structures to support holistic care. With these actions, care that meets the principles of Inclusive Health, characterized by welcoming spaces, effective communication, clinician and staff awareness and training, and sustainable, intentional, and long-term inclusion for individuals with I/DD in the health care system, is achievable.



APPENDIX

Appendix Contents:

1. Example of Coding Requirements – Medicare Chronic Care Management
2. CY 2025 PFS Coding Additions

Example of Coding Requirements – Medicare Chronic Care Management

As one example of the coding difficulties that accompany certain codes that could be used to reimburse clinicians for care for people with I/DD, details on the Medicare chronic care management (CCM) code are included below. Medicare requires extensive documentation and activities to bill for these services, which can be used for patients who have two or more documented chronic conditions over the last 12 months. Reimbursement ranges from \$40 to \$120 monthly, based upon the Medicare PFS rates associated with the provider's locality, and the Medicare beneficiary is subject to coinsurance and deductibles for the services included.¹⁴

Eligible Providers and Core Billing Requirements

Clinicians eligible to bill for this code are:

- Physician, nurse practitioner, physician assistant, certified nurse midwives & clinical nurse specialists, clinical staff (pharmacists, medical assistants, technicians, nurses, therapists) (not within scope of license for podiatrists, clinical psychologists or dentists).
- Billing provider required to furnish an annual wellness visit, initial preventive physical exam (IPPE) or comprehensive E/M prior to billing CCM for new patients or patients not seen within last 12 months - Established patients may be contacted verbally or through email.
- Must provide "timely access" to electronic patient records.
- CCM services may be provided by clinical staff under direction of billing practitioner on an "incident to" basis (as an integral part of services provided by billing practitioner), subject to applicable State law, licensure and scope of practice.
- Clinical staff are either employees or working under contract to billing practitioner whom Medicare directly pays for CCM under "General" supervision; not the usual "Direct" supervision.
- Only one provider (who wrote plan of care) allowed to bill monthly.
- Spent at least 20 to 60 minutes or more (every 30 days) coordinating care.

- Time spent directly by billing practitioner or clinical staff counts toward threshold clinical staff time required to be spent during a given month to bill CCM services. Non-clinical staff time cannot be counted toward threshold.

Documentation

Documentation must include:

- Include narrative detailing need for CCM.
- Support beneficiary eligibility.
- Include a comprehensive care plan (with measurable goals) established, implemented, revised or significantly monitored.
- Patient or caregiver must be given a copy of care plan. Medicare does not specify a certain format for care plan.
- Include the CCM discussion narrative with beneficiary and his/her (verbal (for patients who have been seen in the practice within past 12 months) or written) prior permission acceptance.
- Verbal acceptance must be documented and must be explained to patient for transparency.
- Beneficiary may terminate consent at any time.
- Support services rendered.
- Include time spent on CCM services.
- Support provision of at least 20 or 60 minutes of CCM services for month billed (based on specific procedure code billed).
- Regarding the use of certified electronic health record (EHR) - It is required to standardize the formatting in the medical record of core clinical information (demographics, problems, medications, medication allergies, however; certified technology no longer required for other CCM documentation).

CY 2025 Medicare Physician Fee Schedule¹⁵ (PFS) Coding Additions

Advanced Primary Care Management (APCM)

The proposed coding and payment policies will incorporate elements of several specific existing care management and communication technology-based services into a bundle of services that reflects the essential elements of the delivery of advanced primary care. There are three proposed HCPCS G-Codes for APCM:

- HCPCS code GPCM1 - Advanced primary care management services furnished to patients requiring primary care provided by clinical staff/physician/other qualified health care professionals who are responsible for all primary care and serve as the continuing focal point for all needed health care services, per calendar month.
- HCPCS code GPCM2 - Advanced primary care management services furnished to patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff/physician/other qualified health care professionals who are responsible for all primary care and serve as the continuing focal point for all needed health care services, per calendar month.
- HCPCS code GPCM3 - Advanced primary care management services furnished to Qualified Medicare Beneficiaries with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff/physician/other qualified health care professionals who are responsible for all primary care and serve as the continuing focal point for all needed health care services, per calendar month.

Caregiver Training Services

CMS proposes to establish new coding and payment for caregiver training for direct care services and supports. The caregiver training codes for direct care services and support focus on specific clinical skills aimed at the caregiver effectuating hands-on treatment, reducing complications, and monitoring the patient. CMS is proposing five new HCPCS codes for Direct Caregiver Training Services and proposes to add these services to the Medicare Telehealth Services.

- GCTB1 - Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes.

- GCTB2 - Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service).
- GCTD1 - Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face; initial 30 minutes.
- GCTD2 - Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service).
- GCTD3 - Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face with multiple sets of caregivers.

Increased Access to Behavioral Health Services

These proposed changes include establishing payment for safety planning interventions for patients experiencing behavioral health episodes. CMS previously sought stakeholder feedback on whether there is a need for payment for interventions furnished in the emergency department (ED) or other crisis settings for patients at risk of suicide. CMS also proposes to establish reimbursement for protocols related to post-discharge follow-up contacts that are performed in conjunction with a discharge from the ED for a behavioral crisis encounter.

In addition, CMS proposes to establish payment for digital mental health treatment (DMHT) devices used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. Reimbursable DMHT devices would need to be cleared by the Food and Drug Administration (FDA) and deliver a mental health treatment intervention that has a demonstrable positive therapeutic impact on a patient's health. The billing practitioner would also have to diagnose the patient and prescribe or order the DMHT device for payment to be made.

Office/Outpatient Evaluation and Management Codes

CMS proposes to permit reimbursement for the office/outpatient (O/O) E/M visit complexity add-on code, G2211, when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

ABOUT LEAVITT PARTNERS

Leavitt Partners (LP) has been at the forefront of health policy development for more than three decades. The firm is comprised of professionals whose experience spans the executive and legislative branches of government. As former congressional staff and executive branch political appointees, its team members know the regulatory and legislative processes firsthand and are respected for integrity, expertise, and a record of success. LP helps clients understand and navigate the legislative and regulatory environments to create opportunities, resolve problems, direct action, and build and maintain positive interactions with key federal policymakers.

Our team in Washington, D.C. has deep federal policy expertise, having helped write significant health care legislation and regulation during their time in public service. We have been involved in developing most of the major health care legislation over that time, including Medicare Part D, the Affordable Care Act, the Drug Supply Chain Security Act, the Medicare Access and CHIP Reauthorization Act (MACRA), the Comprehensive Addiction and Recovery Act, the 21st Century Cures Act, the Mental Health Reform Act of 2016, the Bipartisan Budget Act of 2018, multiple FDA User Fee Acts, the SUPPORT Act in 2018, the Pandemic and All-Hazards Preparedness Act and its reauthorizations, multiple COVID-19 relief packages, and the health care provisions of the Consolidated Appropriations Acts of 2021, 2022, and 2023, including the major provisions related to mental health, substance use disorder, and pandemic preparedness.

Additionally, Leavitt Partners is home to expert conveners with decades of experience in the private sector and government who have spent years fine-tuning the process for building successful alliances that bring multi-sector stakeholders to the table with a commitment to reaching consensus, real-world solutions. Leavitt Center experts have helped more than 50 alliances achieve impactful outcomes, including the Dual Eligible Coalition, the CARIN Alliance FHIR accelerator, the Helios FHIR accelerator for Public Health Data Modernization, the Pharmaceutical Distribution Security Alliance (PDSA), COVID Patient Recovery Alliance, and the National Alliance to Impact the Social Determinants of Health (NASDOH).

ABOUT HEALTH MANAGEMENT ASSOCIATES

Founded in 1985, HMA is a leading independent, national research and consulting firm that provides technical assistance and training, facilitation and strategic planning, research and evaluation, policy development and recommendations, technical report writing, and analytical services with a focus on improving the administration and delivery of public health, health care, and social services programs. HMA's team includes approximately 800 consulting colleagues and more than 950 total employees across all HMA companies, who have provided services in all 50 states, the District of Columbia, and several U.S. territories. Our offices are headquartered in Okemos, MI, and has offices in more than 20 states and Washington, D.C.

HMA has distinguished itself from other consulting companies by our decades-long tradition of hiring senior-level experts, such as former state and local public health leaders, directors of community-based organizations, and former senior officers from key federal agencies. We understand the complexity of designing and implementing change at more than just a theoretical level—we have walked in the shoes of our clients and understand how to provide insight that is meaningful, actionable, and realistic.

ABOUT INSTITUTE FOR EXCEPTIONAL CARE

Institute for Exceptional Care (IEC) is a national nonprofit working to make health care better and safer for people with intellectual and/or developmental disabilities (I/DD). IEC partners with people with lived experience of IDD, family members, and health care professionals to change the way care is taught, delivered, and paid for by creating tools, programs, and campaigns. The organization was founded by health care experts in health care delivery, financing, payment, and policy, who also have disabled loved ones and has a track record of building broad coalitions of clinical organizations, payors, purchasers, regulators, consumer advocates, and disability service/advocacy organizations to improve patient health.

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