Healthcare Regulatory Round-Up #83 Webinar Transcript

2025 Medicare Physician Fee Schedule Final Rule – Part 1

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SPEAKERS

Martie Ross, Valerie Rock, Miriam Murray, PYA Moderator

SUMMARY KEYWORDS

Medicare Physician Fee Schedule, MPFS, payment rate reduction, reporting overpayments, new Advanced Primary Care Management, APCM model, telehealth coverage, Federally Qualified Heath Centers, FQHCs, and Rural Health Clinics, RHCs, conversion factor, MACRA legislation, budget neutrality adjustment, telehealth cliff, advanced primary care management, care management services, telehealth services, RHCs and FQHCs, vaccination reimbursement

WEBINAR SUMMARY

The webinar covered the 2025 Medicare Physician Fee Schedule Final Rule, focusing on five key topics:

1. The conversion factor for 2025 is $32.35, a 2.9% reduction from the previous year.
2. The overpayment reporting rule now requires a knowledge standard and a 60-day refund period, with a potential 180-day investigation extension.
3. The new Advanced Primary Care Management (APCM) model includes three codes for care management services, with no monthly time requirement.
4. Telehealth services will face significant changes, including geographic and originating site restrictions.
5. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will see changes in billing practices and reimbursement rates for care management and vaccination services.

ACTION ITEMS

- ☐ Analyze the impact of the conversion factor reduction and advocate for Congress to address the payment cliff.
- ☐ Review and update policies and procedures to address the new requirements for reporting and investigating overpayments.

- ☐ Assess readiness to participate in the new APCM model, including obtaining separate patient consent and meeting the service elements and performance measurement requirements.
- ☐ Prepare for the changes in telehealth coverage, including the use of modifiers and the extension of certain flexibilities.
- ☐ Analyze the impact of the changes for RHCs and FQHCs, including the transition to billing CPT codes for care management services and the new reimbursement methodology.

TRANSCRIPT

PYA Moderator 00:01

Thank you for joining us. The webinar will begin shortly.

Good morning, everyone. Welcome to the latest episode of PYA is healthcare regulatory roundup Webinar Series. Today's topic is 2025 Medicare Physician Fee Schedule, Final Rule part one, PYA is happy to present today's webinar on this important topic. You may submit questions during the webinar by typing a message into the questions pane of the control panel. Also immediately following the end of the webinar, you'll be asked to complete a short survey and submit any additional questions. We will respond to questions posed after the webinar via email. We've posted in the handouts pane of the control panel a PDF copy of the slides for your reference. Also, you'll receive an email later today with a copy of the slides and a recording of the webinar. With that, I would like to introduce our presenters, Valerie Rock, Martie Ross, and Miriam Murray.

Martie Ross 01:25

Thank you, Jennifer, and thank you everyone for joining us today and our first of three deep dives into the Medicare Physician Fee Schedule final rule, the rule published on November 1, and it weighs in at about 3300 pages. And my colleagues Valerie Rock and Miriam Murray have with me, delved through several of those pages to address five topics today, including the payment rate reduction, reporting overpayments, the new APCM model, telehealth coverage. And then we'll wrap up with FQHCs and RHCs that for some reason, for years and years, have also been part of the Medicare Physician Fee Schedule final rule. But I want to introduce you to Valerie and Miriam.

Valerie Rock 02:11

Sure. Thank you. Appreciate everybody joining us today. I'm Valerie Rock. I'm a principal with PYA. I'm coming out of the Atlanta office, if you will, though working from home and as many of you are probably as well and look forward to sharing our thoughts with you today. Miriam.

Miriam Murray 02:30

And I'm Miriam Murray. I am out of the Charlotte North Carolina office, and I work in the regulatory compliance as well as the revenue integrity divisions of our consulting group. And back to you, Martie.

Martie Ross 02:45

Thank you, ladies. I think most of you probably know I'm in the firm's Kansas City office. Of course, go Chiefs, right. Let's start out, just to highlight again, this will have two more webinar series, two more webinars, excuse me on the fee schedule after the Thanksgiving holiday, you see there on your screen the topics that will cover on December four, and then a week later, the topics will round out on December 11, then we will shut down the house until the New Year.

But let's start with the money. Show me the money. Let's talk conversion factor. It's always bad news, and it's the same story that we talked about in the proposed rule. And to provide you perspective on how we get there, I always like to start at the beginning, because we probably have ahead of us some advocacy work to convince Congress to fill the gap in physician payments for this year, but longer term, really reevaluate the system, which is proving, after about a decade, really not meeting our needs. Story goes back to the Medicare Access and CHIP Reauthorization Act 2015 or MACRA. It was legislation with very broad, partisan, bipartisan support, because it was replacing a very broken system, which was the sustainable growth rate formula for calculating the conversion factor beginning at about 2001 we saw that that formula was causing significant cuts year after year, to the tune of 25% in certain years. And so the industry every year trips up to Capitol Hill and Congress would go through the process of the doc fix again.

We seem to be finding ourselves there again. But what we replaced the SGR with was a set of annual payment increases, as opposed to any sort of adjustment for inflation. And where we set today in 2025 is the last year of statutory 0% increases. Where we go at 2026 is then adjustments based on whether you're a participating practitioner in an alternative payment model or whether you remain strictly on the fee schedule. Rule, there'll be annual increases going forward based on the category of you fall into. But important to note here, unlike all the prospective payment systems, the fee schedule does not have an inflationary component to it, and that's why, again, we find ourselves stuck in this year over year reduction in the conversion factor, and thus the corresponding reduction in fee schedule payments. You can also blame MACRA for everyone's favorite the Quality Payment Program, the MIPS program, which again provides separate adjustments to payments based on your score across certain quality measure, quality, and other measures you're probably familiar with how we calculate fee schedule payments.

Every service that's reimbursed on the fee schedule has an assigned relative value. Three components to the relative value, work, practice expense and malpractice expense. You multiply the relative value by a conversion factor that gives you a national payment rate. There's a different formula for anesthesia. We're not going to discuss that here. Just know that it's different. What the conversion factor then draw? How you calculate the conversion factor is how you split the pie. There's a set amount of money available for Medicare Physician Fee Schedule spending. CMS estimates the number of RV use to be performed in the upcoming year, and then divides the pie accordingly, and that gives you the conversion factor. There's a requirement by statute that if CMS in developing the fee schedule determines that it's made changes that will increase expenditures or decrease expenditures by more than $20 million it then has to adjust the fee scale. It has, excuse me, has to adjust the conversion factor to preserve budget neutrality.

So, historically, what we've seen in the last several years are negative budget neutrality adjustments as CMS has brought online new types of coverage. So, last year, you know, we introduced G20 211 which

is the complexity add on code. And because CMS estimated that providing that new coverage would result in at least 20 million more expenditures, there was a conversion factor adjustment to account for that. Similarly, if you go back to 2021 when there were significant adjustments made to the EM codes again, that necessitated that negative budget neutrality adjustment you see on the screen here, just again for your reference in the future, additional adjustments that are then made based on the national payment amount to determine the exact payment made to a specific practitioner under the fee schedule for a certain service.

So, over the years, the last five years have been nothing but bad news when it comes to the conversion factor and a series of very concerning payment cuts, followed by Congress stepping in and providing some degree of adjustment. Last year in 2024 when we had this conversation, we were talking about a potential conversion factor of 3275 in March, Congress stepped in temporarily adjusted that up to $33.29 with a one-time 2.9% increase. So, that's where we are today, where we buy historically. I mean, the cumulative effect of this has been significant, that since 2020 through the current year, 2024 we've reduced the conversion factor by $2.80 that's almost an 8% reduction in payments made on the fee schedule. When, of course, you look at the comparison to the Medicare economic index, which has been increasing significantly year after year. So, we're not going anywhere but backwards in this particular formula.

So, where we get for 2025 CMS calculates the conversion factor at $32.35 which is about a 2.9% reduction over the current conversion factor. How we got there is because when Congress acted last year, its increase was temporary. It was only through the end of 2024, so we lose that adjustment upwards the conversion factor. You go back to MACRA, as I said previously, we're on a zero-factor adjustment for 2025 and then there's actually a little bit of good news. CMS, for the first time in my memory, actually had a positive budget neutrality adjustment because determined changes it made the global surgery codes, which we'll talk about in the next webinar series.

The next episode of the webinar series, the changes it made there, it determined actually shrunk the RV use it anticipated being provided, and so it provided for a positive budget neutrality adjustment. Interestingly, the proposed. Rule that actually had a higher positive budget neutrality adjustment of 0.05 without explanation in the rule, they actually reduced that down to point two. So, that's how we end up with a conversion factor of $32.35 CMS will tell you their hands are tied, and at this point it's up to Congress to decide if there's going to be a doc fix, so we'll be watching carefully see if our lame duck Congress doesn't lay an egg, and in fact, gives the docs a fair compensation under the system.

I would be remiss not to talk about what CMS didn't do in terms of a positive budget neutrality adjustment. We all know, and Miriam will go into greater detail on this subject soon, that we are on the telehealth cliff that again, absent congressional action, all the telehealth flexibilities that we've enjoyed since the beginning of the COVID 19 pandemic in March of 2020, will all come to an end at the end of this year. Meaning that the geographic and originating site restrictions will once again be imposed, meaning cover telehealth services, medical telehealth services will only be covered if you are residing in a rural area and present at a facility at the time the services are being provided. If you go back to July the Congressional Budget Office scored determined how much it would cost the federal government to extend those flexibilities for another two years, and they assigned a $4 billion price tag to those extended flexibilities.

So, you would think the reason they're doing that is because they think there'll be more services provided in the Medicare program that would cost more. You would think CMS, in calculating the conversion factor, would take into account anticipated reductions in utilization due to the no longer being coverage in most instances for telehealth services. But in fact, you'll see in the final rule CMS saying we've never considered changes to Medicare telehealth policies resulting in any significant impact on utilization that we would have to make any type of budget neutrality adjustment. So, as you can see, this is having your cake and eating it too for the federal government, because they want to assign a high price tag to continuing the services. But on the flip side, they don't want to pay more due to reduced utilization of telehealth services.

So, for what it's worth, it's why, certainly, as an industry, we need to be watching carefully what CMS does, pointing out what I believe are obvious inconsistencies in policy as we look now again, to Capitol Hill in the next several weeks to solve this budget, this payment cliff that providers find themselves on. I'm going to get off my soapbox here. Hand it over to Valerie to talk about the provisions in the final rule regarding reporting over payments.

Valerie Rock **12:57**

I'll say with the telehealth piece, as well as everything that we've heard so far is that it will be extended for another year. They can't afford to extend it two years at this point, based on that CBO report, but they're expected to at least get another year out of it, and then they'll decide what to do. So, you know, with everything up in the air the way it has been over the, you know, past few months that was intended or expected at least. So, we should see that, probably around December 20, when everything gets either passed or not passed on continuation of the government. So, well, we'll wait and see.

I want to take a few minutes to talk about this overpayment rule change. So, you might know of the 60-day rule. If you don't know, you'll learn about what it was and what it's going to be. But this was proposed within the 2025 Medicare Physician Fee Schedule proposed rule. But originally, we had some changes proposed in 2022 so that rule was not finalized. And so now CMS has come back and said, “Well, we're going to work on this now, within this 2025 Medicare Physician Fee Schedule, and get these terms finalized so that we can then move forward, though this other proposed rule remains on, not finalized, though it is consistent.” So, what has changed and who is impacted includes the change from a reasonable diligence standard to a knowledge standard? We went from that we have reasonable we performed reasonable diligence to determine and identify an overpayment, and now we have 60 days to refund that back to Part A or Part B, you know, to CMS or that we know to that we have as knowledge standard, using the terms from the False Claims Act of knowing and knowingly.

The False Claims Act, you know, then is, you know, kind of that provision that is more in the law versus this kind of sub regulatory text of reasonable diligence. So, now we have something tying back to the FCA that we have knowledge of an overpayment, and that's when that identify identification occurs. So, who's impacted? That's parts A, B, C and D. But if you're a provider, don't be afraid from A, C and D perspective. Part C is Medicare Advantage. Part D is your drug plan sponsors. So, the plans and the sponsors are the ones that are implicated by this knowledge standard and the 60-day rule, the providers are implicated on

the parts a and parts B side. So, your inpatient, your outpatient services will be impacted on this as you have, historically, you know, seen that.
So, next slide. So, let's take this to the next level. I'm going to talk further about A and B, because C and D only change that knowledge standard, whereas Parts A and B have additional changes. So, again, that knowledge standard under the False Claims Act defines an overpayment as being identified when a provider or supplier has actual knowledge of the existence of an overpayment or acts in reckless disregard or deliberate ignorance of an overpayment, the additional change that was made then in this kind of additional sub bullet, under 401.305, B3, this is where the actual change is, or additional language is, is relevant to an 180-day time period for investigation.

So, now you have the ability to suspend, by law, under this rule, to suspend the 60 days of a refund period, 400 100 up to 180 days. So, a suspension of the applicable requirements for 180 days to conduct a timely good faith investigation to determine the existence of related overpayments that may arise from the same or similar cause or reason as the initially identified over payment. So, then you see suspension of 180 days, you have the ability to conduct an investigation in a timely and good faith manner, and then it also includes those same or similar overpayments. So, the investigation is not just the overpayment that you've kind of identified from the front. It is also similar overpayments. So, this may be systemic issue that you've found.

Now, one thing to note is that we were working from a quantification standpoint. So, when you quantify an overpayment, then the 60-day rule, you know, or 60-day clock, and then it's applied, and you start that 60-day clock to start your refund. This no longer applies. So, now, when you know you have an overpayment, the 60-day clock starts. So, we're going to talk about how that works. There's no reference to credible evidence many of us have been working on. When we identify that there's credible evidence of an overpayment, then we start our 100 and day 80-day clock, or six-month clock of investigating that, you know, overpayment. And then once we've identified that overpayment by quantifying it, then we have 60 days. So, generally, we've had an eight-month time period. We still are going to have an eight-month time period, but that is going to change a little bit.

So, next slide, Martie, the way we've kind of pulled this together, to simplify it for you, is to show, okay, what if, where were we, and where are we going from here on out? So, through December 31 of 2024 it was historically, again, we were identifying credible evidence. Now this was a lot, you know, a lot of this interpretation of how we've done this was in the preamble of the rule. It was not within the body of the rule. It was very up in the air on how you should actually apply this legally. And so, there was a lot of interpretation allowed. What CMS has done is said, “We're putting it within the statute, we're putting it within the rule.” And so now you have guidance on what to do.

So, what we have historically done is taking the identification of credible evidence and started the clock of 180 days. We then investigated for up to 180 days, and then on the identification of that quantification of the overpayment, we said, “Okay, now we have 60 days to refund this.” So, we refunded that overpayment within 60 days. Now, day one is knowledge. We have knowledge of an overpayment. Now, how do we identify that we have knowledge of an overpayment? Because this is a term of FCA of the False Claims Act. There's a lot of case law around the interpretation. Of this term. So, your counsel can

then do an analysis according to case law of your fact specific circumstances and align those to other facts and circumstances of other cases and determine if you have identified an overpayment.
So, what does that really mean? Is that you're probably going to have to go back and say, "Okay, talk with your counsel and say, 'How are we going to buy policy generally apply this? How are we going to interpret when we've identified an overpayment?'" And then apply that within your requirements, within your own guidelines of how you're going to address a 60-day rule? So, again, day one, we've identified an overpayment, then we're going to take that 160-day, or 60 days, sorry, where we have a 60-day time period to refund that overpayment. If, as of say, day 10, for example, you start an investigation, you can suspend that 60 days for up to 180 days. Now you're investigating that overpayment for up to 180 days, and then once you've completed that investigation and determined the overpayment, then your 60-day clock starts again. So, now you're picking up that 60 days. So, now you're on the day 11, and you have the remainder of that 60 days to refund.

So, there's a couple of examples provided within the comment section and responses. So, you can see, it says 10 days. It says 20 days within that 60-day time period. And then you suspend for 180 days, up to 180 days. And then once you've completed that investigation, not at 180 days, but it once you've completed the investigation, then that clock starts again. So, that's the difference between these two things. So, print this page out so you can start applying this.

Next slide. There was one additional change within the b2 of this section of the Social Security Act that they wanted to change us slightly because their circumstances, when additional time might be needed, an additional suspension of the 60-day rule effectively would be needed. For example, you submit for self-disclosure to the OIG or to CMS, or you have extenuating circumstances that you need to address, then you can go to CMS and say, "We need additional time." What they wanted to revise is to say, "This might be after the 180 days of investigation." So, you may have 180 days of investigation and then request additional time if you're now, you know, disclosing to the OIG or CMS, or have extenuating circumstances. So, that's a revision there.

So, in the next slide, we've provided some key responses to comments. So, as you may know, in the proposed rule, we have a 60-day time period to comment and then CMS response to us, and in the final rule, you know, based on those comments so those that gives us some color and is part of the rule, then of what we have to apply, this elevates the risk if we're going against any of this and this, this plays a factor in this last bullet. But to start from the top part of this was trying to define the terms. So, a lot of commenters said, "What does 'receives and retains' mean when we're defining overpayment under the SSA, under 1120, 8J?" They said, "Use plain language meaning of those terms so you've received or retain or retaining an overpayment." Similar to that. They said, "Well, what does 'timely and good faith' mean?" And they said, "Use the plain meaning of those." So, what we have an advantage to this timely and good faith perspective is a time frame. So, we have the 60 days, we have the 180 days. If we're being diligent through those time periods and getting everything within there, or following through with this additional extension, then we can show that we're doing something by good faith.

Now that's Valerie's interpretation of that, not your legal counsel's interpretation of that. So, make sure you get interpretation from your counsel. But an additional piece of this is, as I mentioned, there's a lot of

case law around FCA and how we're going to apply this knowledge standard. So, CMS continuously said we're not going to explain this further. There are plenty of examples out there of how this is applied to identify an overpayment, so utilize the case law to determine your fact specific circumstances. So, that's where we're at with that. But there's an additional piece to this that I think is important. But before we get to that, there are a lot of people that said, "Well, what about our liability? You're basically increasing CMS, our FCA potential liability by implicating this within this kind of diligence per, you know, time period of trying to figure out when our investigation is complete?" and things like that, and "Aren't you just increasing our liability under FCA?" And they said, "Well, we believe that the allowance of 180 days and the allowance of 60 days is sufficient to keep you from, you know, implicating this liability." So, then another piece is that they were clear on that, you know you have the 60 days to refund. So, your day one is identification of that overpayment. The day 60 is that refund when you need to have that refund complete, but you have the suspension period that you can insert in the middle of that for 180 days the last bullet is the highest risk of all of the terms here.

So, it used to be in the preamble to the 60-day rule that there was a mention of even a single overpayment could give rise to the need for an investigation to review and determine if you have an overpayment. Now inside the comments, a commenter said, "Well, if, even if you, you know, review a single overpayment, then you could potentially need to refund." And CMS said, "Yes, even a single overpayment could, should, should be investigated such that you can, you know, confirm that you've identified an overpayment and refund that that now is in the comments and responses, as opposed to the preamble." So, this elevates the risk in the middle of a case that that CMS or another agency could utilize this in terms of, you know, saying, "Well, you had a single overpayment, and you didn't refund it, or you didn't address it." So, this elevates that risk.

Now, what I would say for application, how do you actually apply this? Because this was in the preamble, and a lot of people came to us and said, well, we need to refund. You know, back in 2016 we need to refund, because even a single overpayment. But how do you actually prioritize and do this? Because you would be chasing your tail all day long if you were refunding based on every single overpayment you've ever identified. So, prioritization is going to be key. Policy and procedures are going to be key, having a robust compliance plan and reacting and addressing refunds on a regular basis is going to elevate your good standing with the government, such that you weren't trying to ignore it. You weren't trying to, you know, not address something that you were putting your resources to the highest and best use of the biggest overpayments that you were identified. So, how do you, you know, address that through policy. I would talk with your counsel. I would work through this with your counsel so that you can address this and make sure that you're ready to show that you're doing your due diligence here.

Anything to add, Martie? Because I know I'm giving the layperson's perspective. You have the council's attorney perspectives. And welcome your thoughts.

Martie Ross **28:02**

No, I think that was stated beautifully Valerie. It really is. It's the attention within the organization to how it's going to approach this, and having that reduced down to policy and procedure and having the

infrastructure in place that can act upon that is of course, going to be the best defense moving forward in the case of any sort of government investigation.

And I agree as well the first thought that I was having as you were going through this, and as I was reading it, having sat in a compliance role, it's going to be so important that your policy is reflective of the steps that you're going to be taking when you identify or have knowledge of overpayment, right, right, exactly.

Valerie Rock **28:49**

Well, I'll turn it over to you guys.

Martie Ross **28:53**

Miriam, let's talk about advanced primary care management.

Miriam Murray **28:58**

Well, let's do, let's do. So the proposed rule had a new service for care management services, which is called advanced primary care management services, or APCM, and the intent behind this is to develop a care management program that is population based for payment.

So, what they expect is to have a consistent payment over each month to support practices in the integration of the additional services and the enhanced requirements that are part of APCM. So, as part of that, and the provider being the focal point and being basically the director of the patient's primary care services and all healthcare services, so they're going to be like in the music. Yeah. So, as part of that, CMS had a quote in their comments that said they anticipate that providers who have an APCM model that meets all of the criteria that they will be billing APCM for all of their patients, that they assume the responsibility for those patients' primary care. So, not just a few. This is literally, if they have the primary care delivery system in place, that they will be billing APCM every month for these patients.

So, there are three codes that go along with the complexity. So, you have the geo 556, which is beneficiaries that either have one or no chronic conditions. You have the g0557 which is beneficiaries with two or more chronic conditions. And then you have the g0558 which is the Q and B's with two or more chronic conditions. The good news is on these, which was in the proposed rule as well, is that there is no monthly time requirement, which means it can take zero minutes, or it can take a lot more time each month. But they recognize that the care needs of a patient fluctuate from month to month. These services are delivered, typically by auxiliary staff, and that it is directed at the general supervision of the provider. So, it's going to be interesting how these services are delivered, as well as for providers who are going to be the primary focal point of these services, meaning they have a longitudinal relationship with these patients.

You will also probably see the g20 211 being attached to the EM services that are being provided by these providers as well next slide. So, these are the service elements that go along with the G with the APCM services, the ones that are in black, if you are a provider who is who is already performing CCM or PCM services, you're already doing these services. You're already doing consent the initiating visit. You already

have a comprehensive care plan. All of those things. The items in red are the new items that will be expected to be incorporated into a APCM model of care.
So, you're going to have to have enhanced communications. You're going to have to have the ability to deep dive into your data, to be able to risk stratify and identify care gaps, and then you're also going to have to report on those performance measures, or have the ability to report on the performance measures. So, there's, there's a lot to come into this. The consent was, there was a big section in the comments and responses from CMS on consent on, can you use a current consent that's already in place for CCM and just roll it over to APCM? The consensus in the response was that there should be a separate consent for APCM services. There was also discussion of a consolidated consent, meaning lumping everything in for a patient to be able to consent, not only to APCM, but to CCM, to RPM, various services that wasn't embraced by CMS based on the response. And in all honesty, you know if you're going to have a consent, you the patient should be consenting to services that they are actually going to receive.

I know Martie and I had a discussion about this as well, and consent is a big one. It can still be written or verbal. It does have to be documented in the medical record as well. But there was a lot that was discussed on the consent side of things.

Martie Ross 34:35

If you're able to, I gotta interrupt, but I or just have a discussion here. I mean, it's actually a positive, because in many instances you're going to be providing this, you'll have this infrastructure, kind of a concierge type infrastructure, right? And the patient may not really be seeing the direct services they're receiving. So, when they get their co pay responsibility, they may be asking questions like, “What am I paying for here?” And that consent conversation allows you to explain, hey, we provide these services at a higher level. We accept infrastructure to support you. So, you need services at two in the morning, someone answers the phone that really the consents the opportunity to explain the nature of these services. So, patients appreciate at the connectivity to a practice that's performing at this advanced primary care level, and it did.

They did go through quite a bit of what needs to be in the consent, the explanation of what these services are, how they're going to be delivered, who's going to deliver them, that there's a cost sharing piece to it. So, there is quite a bit in the commentary and the response that address the consent side. So, having just a CCM consent and rolling it over to APCM was not recommended by CMS that there should be a separate consent that that relates to APCM services. Let's see, yes, a wonderful table 25 just so you know, this is all of the practice level and the service elements that are required for a practice to participate in the APCM model of care. And this is in the final rule. It is the one that we have currently. Is a public inspection copy that's available out there. It is not paginated, by the way, so if you find this table, probably want to do the search feature and type in Table 25 however, if you do pull it up, it's pages 442, and 443, in the PDF version, just so you know, registered till December 9, I think is when they're going to actually publish it In the Fed reg. So, and then you'll have pages, and pages, and pages.

Miriam Murray 37:07

Exactly. So, under the performance measurement, there are four options, however, the first three bullets pretty much if a provider is participating in a shared savings program are also are part of an ACO reach, or making care primary or the primary care first models of care, they are going to automatically meet their performance measurement as long as they have a comprehensive care plan to that is documented as well, because those programs automatically have a component of performance that is already reported and accumulated based off of the claims that they are submitting for those services.

So, the other one is a MIPS eligible provider who has to register and report under the MVP value in in primary care. They did also have some additional comments of, "What if I have MIPS eligible clinician, but they don't either a low volume or a newly enrolled provider?" Well, a newly enrolled provider is going to be waived for a year, and then they will roll in, but a low volume, according to the comments, that CMS doesn't believe a low volume MIPS eligible physician or clinician is going to participate in an APCM model of care because of all of the additional requirements that come along with an APCM program and the resources that are required to perform an APCM program. So, don't know if that's true statement or not, but that's their comment.

So, the performance measures is a biggie, and it's one that is a requirement of the APCM program. Any additional commentary, all right, well, the medical record documentation, they did even put that in the final rule, which was kind of nice of them. There is the comprehensive care plan. That's a big piece of the APCM program, as well as a CCM program, or PCM program as well. It does have to be electronic. You do have to participate in a cert EMR that has to be part of the program. It goes to meaningful use, and that is one of the pieces that they state that have to be in there. This quote was quite interesting, that they put in there, and that they said they expect that the actions will fall within the APC elements in the medical record, and as appropriate, that relationship to the to the clinical problems are intended to resolve blah, blah, blah. Okay, it just basically is telling you, you've got to document what you're doing in the medical record. It needs to be in there, if there's, you know, a contact with the patient, what was said was their treatment? Was there any changes in their care plan? Those are the kinds of things that they're going to be looking for in the medical record to support the APCM services. So, we need to make sure that that is something that you take note of.

But what if you don't do services that month the patient is a no or limited conditions, and you didn't have direct contact with that beneficiary? So, this is some of the things that that they did, you know, address in there, and they have said that this, the assumption is that those beneficiaries may or may not receive services each month, but basically, a provider is still going to bill for those services, even if they didn't do anything that month. The care needs fluctuate, as they said in the rule as well. There may be some months that they don't have any needs, but then something happens the next month and that they have a lot of needs, and they say that they have taken account in payment for the fluctuation, we'll see.

Valerie Rock **41:59**

Yeah, okay, it's just…

Martie Ross **42:02**

Yeah, Miriam, this is sort of this round hole, square peg issue, because what CMS is attempting to do is take these demonstration projects like making care primary, where there's a population-based payment, which is calculated based on attributed beneficiaries, and now it's trying to take that model and put it in a straight fee for service. We refer to them as, you know, free range beneficiaries. And how do you determine for which beneficiaries should that practice receive a population-based payment? And this is sort of where they're balancing it out and saying, yeah, if you've got this model and you're maintaining all of these elements, you should receive the payment, but also you have to be providing the service when the patient needs it. So, it's going to be a learning curve, shall we say, as we start implementing this model.

Miriam Murray **42:52**

Absolutely. And you know, if, if you are doing services, they did stress that there must be documentation in the record to show what services were provided.

All right, all right, on to billing so a provider who is the focal point of the care. Can bill for these services once per calendar month. They have to make sure that they are assuming they are the primary director of the services in order to be able to bill for those services. The other thing that they said is APCM cannot be billed in the same month by the same provider for CCM, PCM, TCM, interprofessional consultation, remote evaluation of imaging, virtual check-in visits. So, they have specifically said that if a provider is doing CCM, you cannot also bill PC APCM in the same month. However, an external or outside provider who is who may be providing CCM services can bill for their CCM services or PCM services or even TCM services. So, for example, your primary care provider may be billing APCM on a monthly basis. They're the director. However, a patient was in the hospital, came out of the hospital and then saw their cardiologist after the hospital visit, and the cardiologist did the TCM visit, the cardiologist can absolutely bill that TCM visit. They are separate. They are not the same as the primary care provider who is billing for the APCM services. They did specifically say that RPM, behavioral health integration and interprofessional consultation services that are provided by outside providers are separately billed. They can be separate, separately billed in the same month as PCM or AP APCM, goodness gracious, too many acronyms.

So, then you get to how's it going to get paid? So, you've got your payment, as you can see, for a under the physician fee schedule for a non-facility provider, they're going to get paid $15 a month for a patient who has one or no chronic conditions that you are managing their care, then you have the two or more chronic conditions. That's the 4885 then we threw in CCM in here, just so you can see where it falls. But one of the things that that they do not address in the final rule is, can you bill? I know this is the million-dollar question. Can you bill CCM instead of APCM in a given month if you have met the criteria for CCM and that you have an established APCM program as part of that practice?

The answer is yes, based on the way the rule is written, they did say that you should be billing for the appropriate care management services that you perform for the patients that you are seeing, so and vice versa. So, for example, you have a patient that's doing CCM on, you are in a practice that has an APCM model of care, but you didn't meet that 20 minutes of CCM. Can you then Bill APCM For those patients?

The answer is yes, but again, you've got consent that you must make sure that you have consent for APCM services, as well as a separate consent for CCM services.

Anything you want to chime in there on Martie or Valerie?

Martie Ross **47:39**

It's an interesting question, right? It's going to come down to, do you have the 20 minutes documented of care management services in the record, and you have the time recorded? You know, obviously the dollars tell you, you build out a CCM. But folks, we've worked with, all of us have worked with that have CCM programs. It is surprising how many months you only end up with 10 minutes and it's a wash. You've never been able to receive compensation for that.

Valerie Rock **48:17**

Again, if you meet the elements of the model, then it's the opportunity to take that $48.85 so seems like you'll have your higher acuity patients that will need more time on a monthly basis, perhaps that would fall into that CCM category, and those that may just be 10 minutes that you know that you can then capture for those additional months. So, that will be good to capture that revenue that's not being captured currently, where you're providing service and not getting paid.

Miriam Murray **48:39**

Yep, yeah. CMS also, in their comments, said they are going to be looking at how these services are being utilized, not only DM but the CCM and the PCM and the TCM services and they're going to be, you know, looking at how these are interrelated. So, something to think about.

Okay, let's talk. So, as Martie so eloquently said at the very beginning, we are on a cliff that is about to end as of December 31 at least, for coverage of medical telehealth services. The medical telehealth services, come January 1, are going to be limited to beneficiaries who are residing in a rural area. And that's just how it is, and that the originating site, whether the if it's a facility, also has to be a rural site. So, the patient has to be located in a rural area. The patient, patient is physically present in a facility at the time of services that is, that is provided, and that facility can be, you know, a rural health clinic. It can be a hospital, it can be a skilled nursing facility, but it also has to be located in a rural area, that the services are delivered by audio visual connection, and that the services have to be approved and on the Medicare telehealth coverage list.

The exception to this is the tele-behavioral health services, which are not subject to the geographic or the originating site restrictions, and they can be performed via telehealth regardless of the geographic location.

There's also the telephone codes for EM, which is the four the 441 to the 443. Those are going away as of the end of the year. So, then we have the telehealth services. So, what they did is they took the telehealth services list, and they divided it between provisional services and permanent services. Some examples of but they basically said all services that are provisional are going to stay on the list for 2025 to give CMS time to evaluate the need for those services and the safety of those services. Some examples are cardio

and pulmonary rehab. You've got the wellbeing coaching, you've got psych testing, just as some examples. And then three additional services that they have added are caregiver training, which is a provisional status, so they're going to be looking at how those services are being delivered. And then you've got the what's the word planking on the P, R, E, P, preemptive counseling for HIV. And then you've got the safety planning and interventions, which goes to suicidal or substance abuse codes, and those have both been given permanent status, which is nice. So, those will be continuing. They have modified the interactive definition to now include audio-only if, there's always an IF in there, if the patient the service is going to be firm, furnished at the patient's home, and the provider has the ability to do audio and video, but the patient chooses either they're unable to connect via video or they choose to not be on video. So, that's the caveat to the audio-only definition of interactive telecommunication services.

They did say that for those services, they want you to add a modifier 93 to indicate that the audio that the services were delivered audio-only, and you will still continue to use modifier 95 for audio and video services. They had also proposed 17 new telehealth EM service codes. They chose to not adopt those, or not finalize those, with the exception of one, which is the virtual visit, which is the 98016. It's basically the same definition as the G2012, and it's just replacing that code the virtual visit is not subject to geographic or originating site restrictions, and that you will continue to use the EM codes that are currently on the Medicare telehealth list and the appropriate place of service code and modifier on the EM codes that are on the telehealth list.

So, some things that of note, these are finalized in this the CPT book and Valerie was so nice to point out that this is going to be confusing, or could be confusing, because commercial players are going to be using these new adopted codes where CMS is not so this is something of note.

Valerie Rock **54:34**

Anything else?

Miriam Murray **54:40**

Then we have the extensions of the telehealth frequency limitations, which is nice. I think everybody was very pleased to see that they had extended this again through 2025 for hospital inpatient subsequent services, nursing facility services and Critical Care consults, so they will be able to continue to do telehealth for those environments, which is a good thing.

I think they are looking at that as well to evaluate how much it's being done, and if they are, are going to continue this after 2025 and then the distance service provider is going to still be able to use their enrolled practice location, for their telehealth services furnished to that are being furnished out of the practitioner's home. So, that's a good, good thing as well. And then you have the virtual presence for direct supervision. And this one was being followed by a lot of providers to say, "Okay, are we still going to be able to do direct supervision via telehealth?" And the answer is yes, that has been extended through the end of the year, and then they have also made permanent a couple of additional direct supervision services, and that's for services that are incident to a physician, services that are usually done by an auxiliary person employed by the physician that has an underlying HCPCS code that is assigned an indicator of five, a PC or TC

indicator of five. Typically, those are diagnostic testing codes. And then they also extended the permanent status for the low-level EM visit, which is the 99221, which is also services that they that do not require the presence of a physician and are also done by auxiliary personnel.

Valerie Rock **56:52**

Say some this is a big deal for infusion services, because infusion services are typically an indicator of five. And so, this allows for direct supervision to be provided virtually in that case. So, yeah, they also said in the comments that they deem these to be of a lower risk, which is why they felt comfortable adding it in for permanent status, which is nice. And then lastly, the virtual presence for resident services. This goes to the three-way telehealth visit, where all three, the patient, the resident, and the physician, are all in separate locations, but they are allowing that to continue for direct supervision as well. So that's a lot.

Martie Ross **57:42**

Well, it's a lot, and we've actually bit off more than we can chew because we are at the hour. But we have one more topic to go, which, of course, is discussion for our specialized providers, rural health clinics and federally qualified health centers. So, if you are limited by an hour, thank you for joining us. But I'm going to go ahead and go through the call. The content here. If you are limited by an hour and you still want to hear this content, remember, we always send out the email in the afternoon that includes a recording of the webinars as well as the slides themselves.

So, for those of you that are willing to push through, let's talk about the changes for RHCs and FQHCs, which this year, were significant. Typically, fee schedule has a few changes here and there, but these are some significant changes we're seeing for 2025 starting with telehealth provided in an RHC or an FQHC, because the rules are different.

Beginning with tele-behavioral health services very similar to what Miriam described previously, was one significant difference. These are considered when you provide telehealth services. Those are considered an RHC or an FQHC visit, meaning the service is going to be reimbursed at the PPS rate for the FQ or the error rate for the RHC provided the service furnished is one that is on the approved list of telehealth services and you use an audio visual connection, unless the patient prefers that you do not use the audio the visual connection, or they don't have the capability to use video connection.

Note for FQHCs and RHCs, the in-person prerequisite is delayed until January of 2026 that requirement that before you initiate tele-behavioral health services, you have to have an in person encounter within six months beforehand, and then thereafter, you have to have an in person visit every 12 months. In the non-FQHC/RHC world, this requirement goes into effect January 1 of 2025. It's just a year delay only for RHCs and FQHCs. So, note also that 12-month check-in visit can be waived based on the specific circumstances, provided the basis for the waiver is documented in the record. That's true also outside the RHC/FQHC space for telehealth services, for medical services, RHCs and FQHCs don't go off the cliff if Congress doesn't act, because CMS is providing that they will continue to provide reimbursement for these services using the same methodology currently in place through the end of 2025 as they evaluate alternatives. Meaning that if an FQ or an RHC provides a service, a medical service, that is on the list of

approved ll services, they will be reimbursed at a flat rate, which for 2025 will be $94.96 regardless of the type of services provided, you will not be paid your air or your PPS rate that's only for tele-behavioral health services. Instead, you'll get this flat rate of $94.26 for those services.
Keep in mind that even if Congress doesn't act and the requirements are imposed again for geographic location and originating site that would not apply to an RHC or FQHC, they will continue to be reimbursed under the special provision for these facilities only. And again, as has been the case for a number of years now, 232, decades, at least, an RHC or an FQHC can bill as a telehealth originating site under Q 3014, in those instances where the patient is physically present at your location and receiving telehealth services from a distance. Sites providers, this is intended to cover your expenses with serving as an originating site. Again, see CMS continues coverage for virtual communications services that are furnished through an RHC or an FQHC, these are billed by the clinics under G071 with that about $14 in reimbursement for those services. Keep in mind the billing rules that apply that this cannot be a substitute, or it is a substitute for a face-to-face visit, and it cannot be billed if it's within a certain period of time of a face-to-face visit.

Significantly, CMS is changing the rules on how FQHCs and RHCs provide care management services. So, today, if an RHC or an FQHC provides one of the services you see listed here on the screen, rather than billing for that service under the assigned CPT code they list on the claim geo 511, which is the general care management code, use the same code, regardless of which of these services that you are providing. That rate for G0511 for 2024 is $72.90, which is based on the average of the non-facility rate for all those services that you see there above.

Separately, if an FQHC or an RHC provides the psychiatric collaborative care model, you're going to bill for that today under G50512, with reimbursement of about $147 beginning in 2025. However, CMS is discontinuing the use of a G0511, and instead requiring FQHCs and RHCs to bill for a face-to-face service using the assigned CPT code. So, this is a non-face-to-face visit, so it does not qualify as an RHC or an FQHC visit. But for these specific services listed here, CMS will reimburse for non-face-to-face visit services, but requiring you now to list the CPT code on the claim form. Note here that this does include that new service that Miriam described advanced primary care management, which can be provided through an FQHC or an RHC. How you get paid now for these services will no longer be that flat $72.90 regardless of what service it is. Instead, you're going to be reimbursed for these services at the National non facility payment rate on the fee schedule. So, if you're provide what, again, look, think of that, that table that Miriam had in her presentation of what the payment is for the non-facility rate for those APCM services, that's the rate that you're going to be paid now as an RHC or an FQHC.

One question they didn't address, and I haven't figured the answer out yet to, is whether the CO payment for these services is going to be based on your charges, which is what it is today, or is it now going to be a COVID copayment based on the Medicare allowable, I think for now, I continue to calculate the CO payment based on your charges, as you have done previously, until we are advised otherwise by CMS. Appreciating a number of comments that said, “We can't turn on a dime and start doing this. We've got to develop the systems to be able to report the CPT code.” CMS is allowing for a six-month transition period. They'll she'll be able to continue to build with 0511, as opposed to the CPT codes through the end of June. Note, however, the CMS has made an adjustment to the reimbursement for G0511 for 2025, and it will go from the 70 to 90 down to $54.67. So we had thought, when we first read this provision of, this is great,

we'll continue to get the higher reimbursement. No. CMS actually reduced the reimbursement down. So, if you continue to bill for geo 511, you'll get that lower weight.
They also know that it's all or nothing. You can't pick and choose when you're going to bill G0511, you have to choose a point you're going to make the transition over to the CPC codes, and for whatever reason, CMS decided that they would continue to have RHCs and FQs built for the collaborative care model under G0512, which in fact, the reimbursement is comparable to what it is on the fee schedule. You see here a table that just gives an example of the impact of this change on RHCs and FQs that have provided these services historically. If you were providing CCM, for example, through an RHC or an FQHC, your reimbursement was higher than it would have been under the fee schedule rate. That's obviously going to change. Now you're going to be billing for the on the CVC on the 994 and I know that reimbursement will be below what you had been previously receiving. But note, however, that you will be able now to build the add on code always been a sort of an open question, previously under G0511, but when you include these add on codes. So, if you're providing 40 minutes of care management services, the reimbursement actually becomes higher than you would have been receiving under G05011. You're just going to take some analysis, crunching the numbers to see where you end up under this other significant change for 2020.

For 2025, concerns vaccinations. So, today, in an RHC/FQHC setting, you provide the flu, the pneumonia, and the COVID vaccines, you're paid at 100% of reasonable costs, and it's settled on a cost report to ensure that you receive the appropriate level of payment. If you provided the hepatitis B vaccine, which again requires the physician order, you weren't getting separate reimbursement because it was rolling into your PPS or air for 2025, CMS is now going to pay for all the Part B vaccines, which includes hep B as well as vaccine administration. You're going to be reimbursed at the time of service. You also will be able to bill for N of O, 201, if you are providing vaccination in a patient's home, but because there's a statutory requirement that these clinics be reimbursed at 100% of their costs, they'll still be an annual reconciliation as part of the cost report, which potentially could mean paying dollars back if you were receiving reimbursement higher than the cost for providing the services CMS promises.

There'll be additional guidance coming out, including Cost Report instructions they'll be released in early 2025 to give us some clarity around that. Otherwise, some changes in the final rule for the rural health clinic conditions of certification and coverage, importantly, no longer requiring that an RHC, more than 50% of an RHCs total hours of operation involve primary care services. So, this is opening up this door for RHCs to be able to provide specialty services without that constant having to count hours to stay in compliance with the 50% rule. They finally are laying that aside, saying it's impossible to survey on. We're no longer going to try, but still require you that you are providing core primary care services as part of your issue there, as part of your services, some modifications, minor modifications, to the definition of clinical lab services that RHCs are required to provide.

A few very other minor changes for RHCs regarding the rates they're paid for intensive outpatient programs. They are eliminating the RHC productivity standards. Yay. Another one of these. You could never sort of survey for it. So, now that they're no longer requiring those, there's a rebase on the FQHC market basket, changing the base year from 17 to 2022, and also some clarifications regarding payment for dental services within FQHCs.

Deep breath, ladies, we made it through. We went over. We apologize for that, but it's a lot of content when you got 3000 pages of rules. Again, after the Thanksgiving holiday, two of these webinars will be covering content in the role both on December 4 and December 11. So, thank you very much again for joining us. Jennifer, back to you to take us home.

PYA Moderator **1:10:12**

All right, thanks to our presenters, Miriam, Martie, and Valerie. Later today, you'll receive an email with their contact information and a recording of the webinar. Also, the slides and recordings for every episode of PYA is healthcare regulatory roundup series are available on the Insights page of PYA is website, pyapc.com.

While at our website, you may register for other PYA webinars and learn more about the full range of services offered by PYA, please remember to stay on the line once the webinar disconnects, to complete a short survey and post any additional questions you may have.

On behalf of PYA, thank you for joining us and have a great rest of your day!