HEALTHCARE REGULATORY ROUND-UP #75

2025 Proposed Rules Part 2: Medicare Physician Fee Schedule

July 31, 2024

Introductions

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Today's Agenda

1. CY 2025 Payment Rate Reduction
2. Deadline for Reporting Overpayments
3. Advanced Primary Care Management Payments
4. Telehealth
5. Federally Qualified Health Centers/Rural Health Clinics

Comments on MPFS Proposed Rule due September 9, 2024


federalregister.gov/documents/2024/07/31/2024-14828/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other
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Proposed Rule
Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments
A Proposed Rule by the Centers for Medicare & Medicaid Services on 07/31/2024
This document has a comment period that ends in 40 days. (09/09/2024)
SUBMIT A FORMAL COMMENT

Parts 3 and 4

- **Part 3 – August 14**
  - Global surgery payment accuracy
  - Evaluation & management services (including HCPCS G2211)
  - New reimbursement for preventive services
  - Digital therapeutics for behavioral health
  - Supervision of outpatient therapy services
  - Opioid treatment programs
  - Skin substitutes
- **Part 4 – August 21**
  - Quality Payment Program (MIPS)
  - Medicare Shared Savings Program
  - SDOH-related services
  - Clinical Laboratory Fee Schedule payment reductions

1. CY 2025 Payment Rate Reduction

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Medicare Access and CHIP Reauthorization Act of 2015

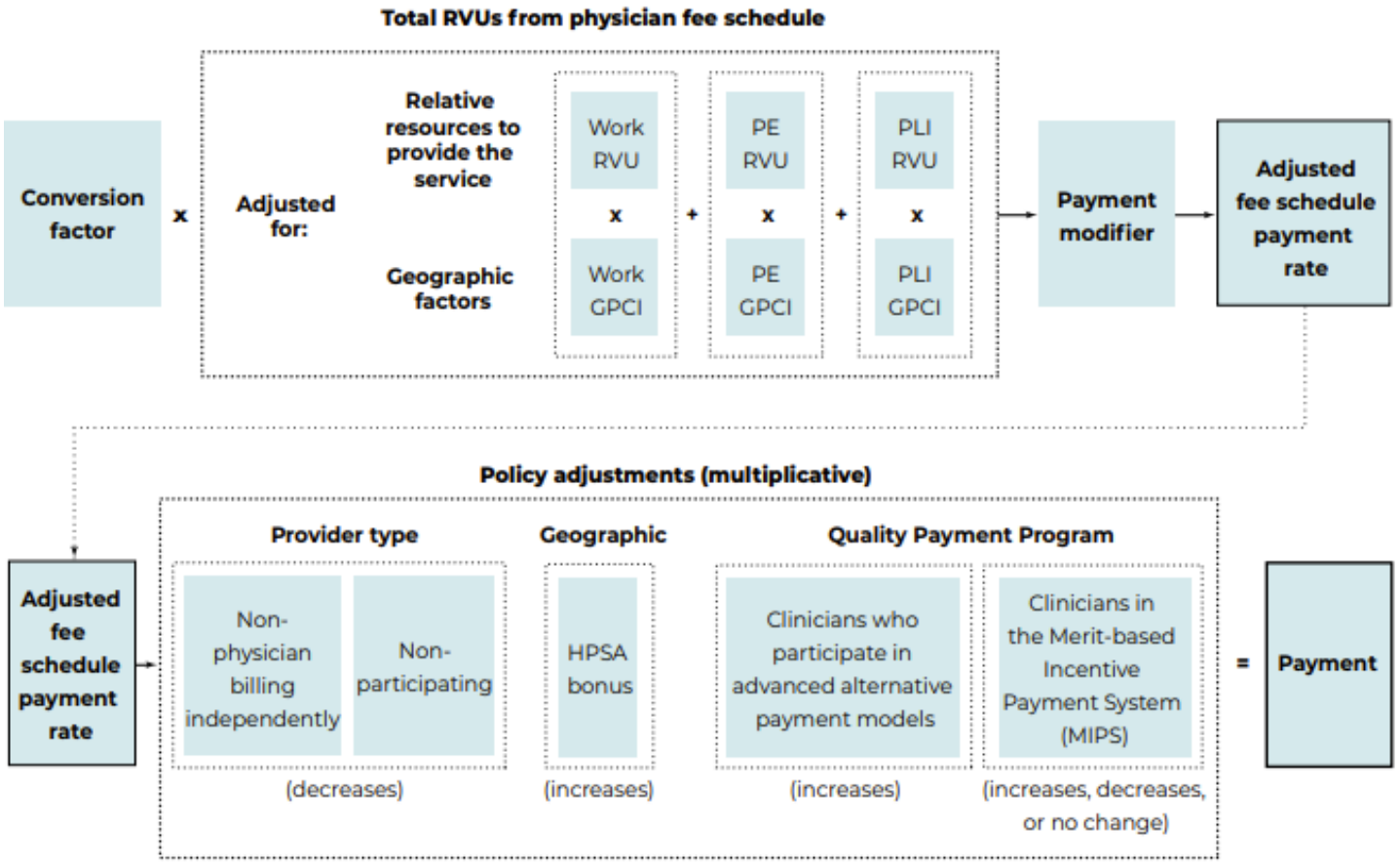
- Passed with overwhelming bipartisan support
  - 392 to 37 in the House; 92 to 8 in the Senate
- Repealed existing Medicare physician payment formula
  - Sustainable Growth Rate (SGR) tied payments to gross domestic product, resulting in significant cuts (up to 25%) beginning in 2001 requiring annual Congressional intervention
- Replaced with specified annual payment increases
  - 2015 – 2019: 0.5% annual increase
  - 2020 – 2025: 0% annual increase
  - 2026 forward: 0.75% (APM participants) or 0.25% (everyone else) annual increases
- Established Quality Payment Program (performance-based payments/penalties)

Calculating Fee Schedule Payments

- **Assigned relative value**
  - Work
  - Practice expense
  - Malpractice expense
- **Conversion factor** (RVU x CF = national payment rate)*
  - Dollar amount based on statutory cap on MPFS spending
  - Zero adjustment factor for 2020 through 2025 (unlike all other payment systems, no inflation adjustment)
  - If any +/- in RVUs causes amount of annual Part B expenditures to differ by > $20 million from what expenditures would have been, CF must be adjusted to preserve ***budget neutrality***
    - Coverage changes (e.g., HCPCS G2211 (complexity add-on code)
    - Misvalued codes (e.g., 2021 E/M adjustments)

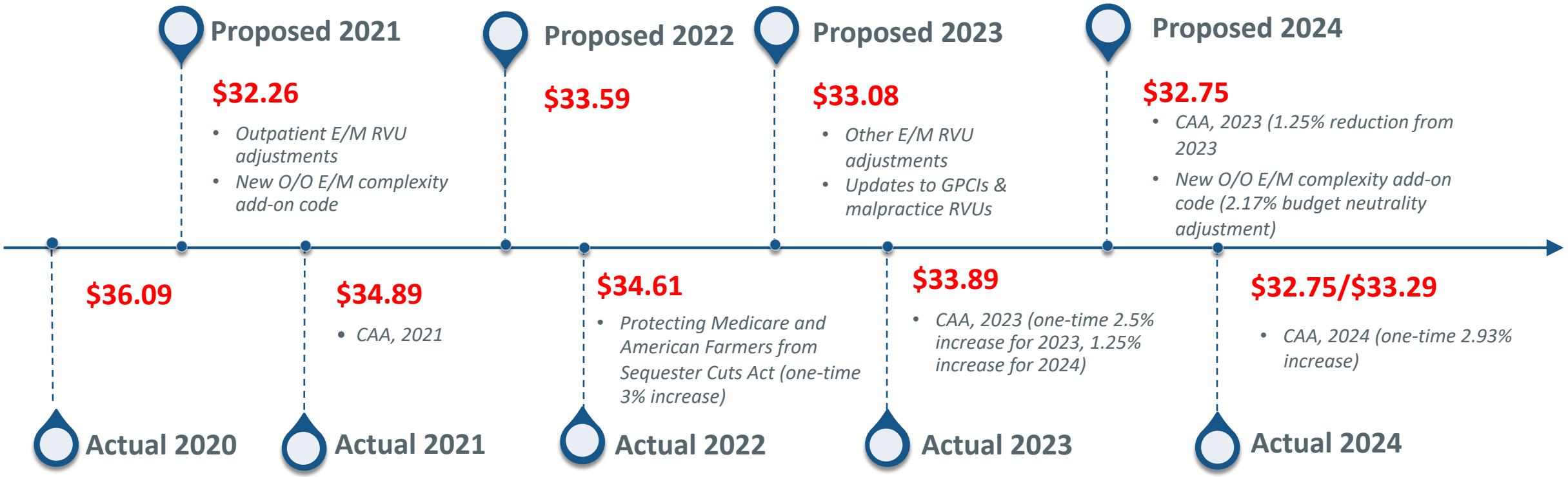
*Different formula used to calculate anesthesia conversion factor

Additional Payment Adjustments



https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf

Conversion Factor – A Brief History (2020 – 2024)



Year	MPFS Final Rule	Congressional Fix	Final Cut
2021	-10.2%	+6.9%	-3.3%
2022	-3.8%	+3%	-0.8%
2023	-4.5%	+2.5%	-2.0%
2024	-3.37%	+1.68%	-1.69% (services furnished on or after 3/9/24)

From 2020 to 2024, conversion factor has been reduced by $2.80 (7.7% reduction)

Medicare Economic Index: +2.5% in 2021, +4.6% in 2022, +4.1% in 2023, +4.6% in 2024, +3.6% in 2025

Proposed 2025 Conversion Factor - $32.36*

- Decrease of $0.54 compared to current conversion factor ($33.29)
  - 2.8% reduction
- How did we get here?
  - Removal of temporary 2.93% payment increase for services furnished 3/9/2024 to 12/31/2024 authorized by CAA, 2024
  - Zero adjustment factor mandated by MACRA
  - 0.05% *positive* budget neutrality adjustment

CY 2024 Conversion Factor		33.2875
Conversion Factor without the CAA, 2024 (2.93 Percent Increase for CY 2024)		32.3400
CY 2025 Statutory Update Factor	0.00 percent (1.0000)	
CY 2025 RVU Budget Neutrality Adjustment	0.05 percent (1.0005)	
CY 2025 Conversion Factor		**32.3562**

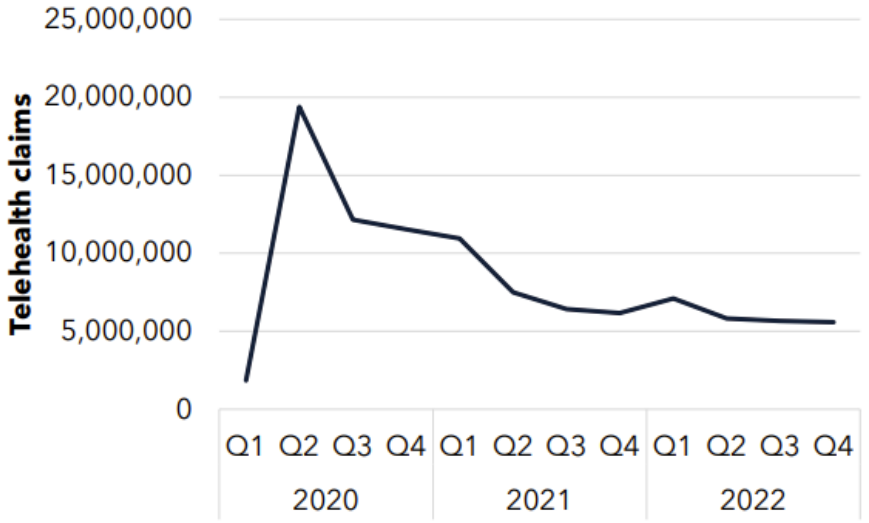
*Proposed 2025 anesthesia conversion factor = $20.33 (down from current $20.77)

Positive Budget Neutrality Adjustment

- Proposed rule includes expanded coverage, but no corresponding negative budget neutrality adjustment
  - Advanced primary care management services
  - Services addressing SDOH + opioid treatment programs
  - Safety interventions and post-discharge follow-up
  - Digital mental health treatments
  - Interprofessional consultations
  - Hospital inpatient/observation E/M add-on for infectious diseases
  - Expanded coverage for G2211, colorectal cancer screenings, hepatitis B vaccination
- Changes to payments for global surgical codes
  - Policy changes re: use of transfer of care modifier = lower utilization
  - Reflected in 0.05 positive adjustment to CF

What About Telehealth?

- 12/31/2024 end of telehealth flexibilities (reinstatement of geographic and location requirements for coverage)
- “Despite the fact that some services will no longer be furnished under telehealth, we expect that they will continue to be furnished in-person”
- No impact on utilization, no budget neutrality adjustment
- So why does Congressional Budget Office estimate 2-year extension will cost ***$4 billion***?



Traditional Medicare Telehealth Utilization

https://www.medpac.gov/wp-content/uploads/2023/10/Telehealth-April-2024-SEC.pdf

2. Deadline for Reporting Overpayments

Image Source: Shutterstock

December 2022 Overpayment Proposed Rule

- Addressed standard for identification of overpayment
  - Modify regulations for reporting and returning Medicare overpayments
  - Remove “reasonable diligence” standard and adopt FCA definition of “knowing” and “knowingly”
    - FCA: includes information about which person “has actual knowledge,” “acts in deliberate ignorance of the truth or falsity of the information,” or “acts in reckless disregard of the truth or falsity of the information”
  - Included Medicare Part C and D
- December 2022 proposed rule still under review
  - CMS intends to address all proposals in 2025 MPFS Final Rule

Reporting Overpayments - 2025 MPFS Proposed Rule

- Addresses Parts A and B only
- Focuses on deadline for reporting and returning overpayments
  - When person who has received an overpayment must report and return
    - Overpayments must be reported no later than date which is 60 days after date on which overpayment was identified or date any corresponding cost report is due, if applicable
  - Circumstances under which deadline for returning overpayments will be suspended
    - Includes acknowledgement of receipt of a submission to the OIG Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol
    - Proposed to include suspension to allow time for providers to investigate and calculate overpayments

Reporting Overpayments - 2025 MPFS Proposed Rule

- Deadline suspended if –
  - Person has identified overpayment but has not yet completed good-faith investigation to determine existence of related overpayments that may arise from same/similar cause/reason as initially identified overpayment **AND**
  - Person conducts timely, good-faith investigation to determine whether related overpayments exist
- Duration of suspension – the earlier of -
  - Date investigation concluded and aggregate amount of total overpayment is calculated
  - Date that is 180 days after date initial overpayment was identified

3. Advanced Primary Care Management Payments

Image Source: Shutterstock

Advanced Primary Care Management Services

- APCM includes 3 new codes:
  - GPCM1 – APCM for patients with one or no chronic conditions
  - GPCM2 – APCM for patients with two or more chronic conditions
  - GPCM3 – APCM for patients with two or more chronic conditions and who are Qualified Medicare Beneficiaries
- Similar elements to CCM and PCM
  - Additional practice capabilities (advanced primary care delivery model)
  - APCM does not have minimum time requirements
- Services can be delivered by professional and auxiliary personnel under general supervision of billing practitioner

APCM Required Elements

- Consent
- Initiating Visit for New Patients (separately paid)
- 24/7 Access to Care and Care Continuity
- Comprehensive Care Management
- Patient-Centered Comprehensive Care Plan
- Management of Care Transitions
- Practitioner, Home-, and Community-Based Care Coordination
- Enhanced Communication Opportunities*
- Patient Population-Level Management*
- Performance Measurement*

* *APCM elements different from CCM and PCM*

APCM Practitioner Requirements

- In addition to CCM/PCM practice-level capabilities, practitioner must furnish services through advanced primary care delivery model
  - Enhanced communication opportunities, patient population-level management, performance measurement
- MSSP, ACO REACH, Making Care Primary, and Primary Care First participants satisfy these requirements
- MIPS eligible provider must register and report Value in Primary Care MVP (to meet performance measurement requirement)

Billing for APCM

- Submission of claim = attesting to compliance with required practice capabilities
- Billed once per service period (calendar month) and only by single practitioner who assumes primary care management role
- GPCM1, GPCM2, and GPCM3 not time-based (no specific activity required in a given month to bill for APCM)
- Billing practitioner/another practitioner in same practice and same specialty cannot bill following services in same month as APCM: CCM, PCM, TCM, interprofessional consultation, remote evaluation of patient videos/images, virtual check-in, and e-visits
  - Can bill for remote patient monitoring (RPM, RTM)
- Medicare cost-sharing applies

APCM Proposed RVUs and Payment Rates

Code	Short Descriptor	Proposed Work RVU	Proposed PE RVU	Proposed Full RVU	Approximate National Payment Rate
GPCM1	APCM - up to 1 chronic condition	0.17	0.14	0.31	$10
GPCM2	APCM for 2+ chronic conditions	0.77	0.72	1.54	$50
GPCM3	APCM for QMBs with 2+ chronic conditions	1.67	1.57	3.36	$110

Table 23: Proposed APCM Bundled Codes and Valuation

Requests for Comments

- From State Medicaid – how they would cover QMB cost sharing, considering lesser-of policies
- Use of QMB status and multiple (two or more) chronic conditions as the basis to bill for APCM Level 3 (GPCM3)
- Consider certain practitioners in other types of CMS Innovation Center models
- Should proposed elements of APCM and practice capabilities be modified or removed
- APCM impact on separately billed CCM or PCM
- Consent for APCM services on ongoing basis and CMS-provided consent template

4. Telehealth

Image Source: Shutterstock

Telehealth

- **CONTINUE** use of current office/outpatient E/M codes on the Medicare telehealth services list
  - POS code to identify the location of the beneficiary
  - Modifier - When applicable, to identify the service as being furnished via audio-only communication technology.
- Use CPT code 9X091 to reflect a virtual check-in – CMS proposes to delete CPT code G2012
- CPT codes 99441-99443 are deleted for reporting telephone E/M services

Telehealth – Proposed Additions and Deletions

- CMS will maintain provisional codes through 2025 while completing comprehensive analysis to determine permanent placement on Medicare Telehealth Services List
  - Remaining provisional (examples)
    - Cardiovascular and Pulmonary Rehabilitation (CPT codes 93797, 93798, 94625, 94626)
    - Health and Well Being-Coaching (CPT codes 0591T-0593T)
    - Psychological Testing and Developmental Testing (CPT codes 96112, 96113, 96130, 96136, 96137)
    - Therapy/Audiology/Speech Language Pathology (various CPT codes)
- **Add** – Home International Normalized Ratio (INR) monitoring (CPT G0248)
- **Add** – Caregiver Training (CPT 97550, 97551, 97552, 96202, 96203)
- **Delete** – Radiation Treatment Management (CPT 77427)

Telehealth – Extensions/Proposals

- Extend through CY 2025 suspension of the frequency limitations for subsequent care services in inpatient (CPT Codes 99231–99233), and nursing facility (99307–99310) settings and critical care consultations (G0508 and G0509)
- Include audio-only communication technology in definition of “interactive telecommunications system” for any telehealth service provided to patient in their home if patient cannot use/does not consent to video technology
- Continue to allow distant site practitioners to use their currently enrolled practice location instead of home address for telehealth services from home through CY 2025

Telehealth – Direct Supervision

- **Proposed permanent:**
  - Virtual Direct Supervision for certain subset of diagnostic services furnished incident to the physician's services when provided by auxiliary personnel employed by physician and under physician's direct supervision
  - **"Direct supervision"** is defined as the physician or qualified NPP is present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.
  - **"Immediate availability"** to include real-time audio and visual interactive telecommunications.

Telehealth – Teaching Physicians

- Virtual presence for purposes of billing for resident services in all teaching settings – meets requirement for physician presence for key portion of the services
  - **Example:** 3-way telehealth visit with the patient, resident and teaching physician, all parties in separate locations

5. RHCs and FQHCs

Image Source: Shutterstock

Care Management Services – HCPCS G0511

- Presently, RHCs/FQHCs bill for care management services using HCPCS G0511
  - CCM, PCM, general BHI, CPM, CHI, PIN RPM, RTM
  - May bill multiple units in calendar month if distinct services (but not add-on codes, e.g., CPT 99439)
  - Current payment rate = $72.90 (weighted average of national non-facility MPFS rates for included services)
  - For psychiatric CoCM, bill HCPCS G0512 = $146.47
- Beginning 01/01/2025, RHCs/FQHCs would bill under individual codes (discontinue payment using HCPCS G0511) with payment at national non-facility MPFS rate for the code
  - Including new APCM codes
- Request for information: Other services that should be paid on MPFS (vs. reimbursed as part of encounter)?

Good or Bad?

- “We note that the payment amounts for some services that made up G0511 are less than the payment amount for G0511 and [clinics]could see a potential decline in payment. We are also proposing to allow RHCs and FQHCs to bill the add-on codes….This could potentially offset any decrease in payments.”

Code	2024B Payment Rate
HCPCS G0511	$72.90
CPT 99490 (CCM, 1st 20 min)	$62.58
CPT 99439 (CCM, each add’l 20 min)	$47.93
CPT 99453 (RPM monthly monitoring)	$47.27

- Copayment amount based on charges or Medicare allowable amount?

Telehealth

- Telehealth -behavioral health services
  - Per CAA, 2023, billed as if face-to-face encounter
  - Delay in-person visit pre-requisite through 12/31/2025
- Telehealth – non-behavioral health services
  - Continue to bill under HCPCS G2025 through 12/31/2025 (2024B payment rate = $95.27)
  - “We solicit comment on whether there may be other payment methodologies that may be a proxy for costs associated with non-behavioral health visits furnished via [telehealth].”
- Direct supervision via 2-day audio/visual connection
  - Continue through 12/31/2025

Vaccinations

- Currently, Medicare reimburses RHCs/FQHCs 100% of reasonable cost for influenza, pneumococcal, and COVID-19 vaccinations
  - Not included in AIR/PPS, no patient co-pay
  - Paid as part of annual reconciliation through clinic's cost report
  - Hepatitis B vaccinations included in AIR/PPS, but cannot charge patient co-pay
- Beginning 07/01/2025, RHCs/FQHCs would bill for administration of Part B vaccinations (including Hepatitis B) at time of service
  - Claims paid like other Part B vaccination claims (95% AWP for vaccine + fee schedule rate for administration (including in-home additional payment))
  - Still complete annual reconciliation to ensure payment at 100% of reasonable costs (including Hepatitis B?)

Conditions of Certification/Coverage

- No longer require >50% of RHC's total hours of operation must involve primary care services
  - Still must provide primary care services, but not at specified level
  - Still cannot be rehabilitation agency or facility primarily for treatment of 'mental diseases'
  - May provide outpatient specialty services within practitioner's scope of practice to meet community needs
- RHC clinical lab services
  - Remove hemoglobin and hematocrit from list of services RHC must provide directly
  - Change "primary culturing for transmittal to certified laboratory" to "collection of patient specimens for transmittal to a certified lab for culturing"

In Other News

- Updated payment rate for Intensive Outpatient Program services furnished in RHC/FQHC
- Elimination of RHC productivity standards (specified # of visits per FTE)
- Re-basing of FQHC market basket (change base year from 2017 to 2022)
- Clarification regarding payment for dental services furnished in FQHCs

Our Next Healthcare Regulatory Round-Ups

August 14: 2025 Proposed Rules, Part 3: Medicare Physician Fee Schedule

August 21: 2025 Proposed Rules, Part 4: Medicare Physician Fee Schedule

September 4: FY 2025 Final Rules

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