RHC Regulatory Changes in 2025 - Medicare Physician Fee Schedule Updates You Need to Know!

NARHC

Rural Health Clinic Technical Assistance Webinar

This webinar is brought to you by the National Association of Rural Health Clinics and is supported by cooperative agreement UG6RH28684 from the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA). It is intended to serve as a technical assistance resource based on the experience and expertise of independent consultants and guest speakers.

Introductions

Nathan Baugh

Executive Director,

National Association of Rural Health Clinics (NARHC)

Sarah Hohman, MPH, CRHCP

Director of Government Affairs,

National Association of Rural Health Clinics (NARHC)

Reminders

- All participants are muted upon entry
- Questions will be accepted via the Q&A box at the end of today's presentation
- For any technical issues please email asst@narhc.org
- Slides will be available via the chat box and can also be downloaded on NARHC.org
- The presentation recording will be available by mid-week
- To receive your CRHCP CEUs as part of your maintenance requirements, be sure to complete the survey at the end of the webinar

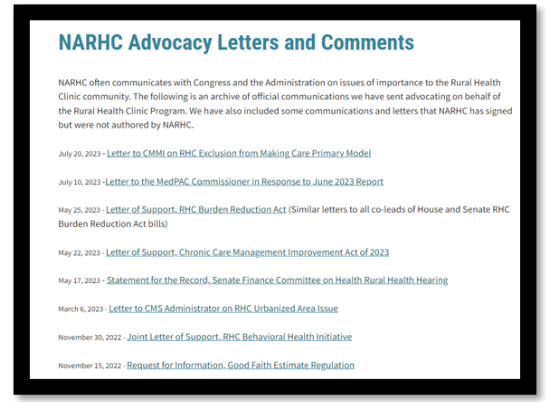
Quick Note

- While we will not be discussing the recent election or advocating on today's call, we encourage you to sign up for NARHC's December 4 webinar.
  - NARHC Advocacy Update - Expectations and Priorities in the 119th Congress

CMS Rulemaking Process

July – MPFS and OPPS Proposed Rules Released

September – Stakeholder Comments Due



NARHC Advocacy Letters and Comments

NARHC often communicates with Congress and the Administration on issues of importance to the Rural Health Clinic community. The following is an archive of official communications we have sent advocating on behalf of the Rural Health Clinic Program. We have also included some communications and letters that NARHC has signed but were not authored by NARHC.

July 20, 2023 - Letter to CMMI on RHC Exclusion from Making Care Primary Model

July 10, 2023 -Letter to the MedPAC Commissioner in Response to June 2023 Report

May 25, 2023 - Letter of Support, RHC Burden Reduction Act (Similar letters to all co-leads of House and Senate RHC Burden Reduction Act bills)

May 22, 2023 - Letter of Support, Chronic Care Management Improvement Act of 2023

May 17, 2023 - Statement for the Record, Senate Finance Committee on Health Rural Health Hearing

March 6, 2023 - Letter to CMS Administrator on RHC Urbanized Area Issue

November 30, 2022 - Joint Letter of Support, RHC Behavioral Health Initiative

November 15, 2022 - Request for Information, Good Faith Estimate Regulation

November 1 – Final Rules Released

January 1 (or later) – Provisions go into effect

- *And then the process starts again!*

What's in the 2025 Medicare Physician Fee Schedule Final Rule for RHCs?

Medicare Vaccine Reimbursement Changes

- *Currently*:
  - RHC statute requires that Medicare preventative vaccines (pneumococcal, flu, COVID-19) and their administration be reimbursed at 100% of reasonable costs
  - The hepatitis B vaccine is currently reimbursed as part of the RHC All-Inclusive Rate (co-insurance/deductible waived)
- *Proposed*:
  - CMS finalized RHCs billing for the administration of pneumococcal, flu, COVID-19, **and** hepatitis B vaccines at time of service
    - Would pay 95% of Average Wholesale Price for vaccine products
    - Administration reimbursed according to the Part B vaccine fee schedule, adjusted for locality (adjustments located at the bottom of the page here)
      - Vaccine Administration Reimbursement:
        G0008 (Flu) -- $33.71 (unadjusted)
        G0009 (Pneumo) -- $33.71 (unadjusted)
        G0010 (Hep B) -- $33.71 (unadjusted)
        90480 (COVID-19) -- $44.95 (unadjusted)
    - To reach 100% of reasonable costs, however, RHCs will still reconcile with CMS via the cost report

Medicare Vaccine Reimbursement Changes

- *At-Home Vaccine Administration Reimbursement*
  - RHC providers can bill HCPCS code M0201 when flu, COVID-19, pneumo, or hep B vaccines are administered in the patient's home
  - Approximately a $39.90 (unadjusted) additional reimbursement. To meet the criteria for receiving the in-home additional payment, RHCs must be in a designated home health shortage area and offer visiting nurse services, and the visit must also meet the requirements outlined below:

    (A) The patient has difficulty leaving the home or faces barriers to getting a vaccine in settings other than their home.

    (B) The sole purpose of the visit is to administer one or more preventive vaccines.

    (C) The home is not an institution that meets the requirements of sections 1861(e)(1),1819(a)(1), or 1919(a)(1) of the Act, or §§ 409.42(a) of this subchapter.

- ***Vaccine reimbursement changes will go into effect on July 1, 2025***

Medicare Vaccine Reimbursement Changes

- *NARHC Ongoing Questions*:
  - Do RHCs have the *option* to bill this way or are they required to beginning 7/1/2025?
  - Billing specific questions –
    - Is there a vaccine specific revenue code that should be used?
    - Can they be on the same claim as other RHC services or on their own and still expect the same reimbursement?

- CMS has already acknowledged the various guidance documents that will need to be updated as well as the cost reporting instructions that will need to be issued.

Elimination of Productivity Standards

- *Currently*:
  - RHC productivity standards are 4,200 visits per full-time equivalent (FTE) physician and 2,100 visits per FTE nurse practitioner, PA, and certified nurse midwife
  - Since all RHCs are now subject to some sort of upper payment limit (either the clinic specific cap for grandfathered RHCs or the national statutory cap for new and independent RHCs), the productivity standards have been less important

- *What CMS Finalized:*
  - Productivity standards are eliminated, effective with cost report periods ending after December 31, 2024**

The effective date above was written in the Final Rule. However, in the CMS Fact Sheet, CMS wrote "effective for cost reporting periods beginning on or after January 1, 2025." CMS has clarified to NARHC that RHCs should follow what is written in the final rule.

Medicare Care Management Reforms and New Opportunities

- *Currently*:
  - Since 2016, RHCs have been able to bill for care management services through a consolidated care management code: G0511 (~$72 reimbursement)
    - Each year, CMS added new services billable under the G0511 code
      - This consolidated code is used when RHCs want to bill for Chronic Care Management (CCM), Remote Physiologic Monitoring (RPM), General Behavioral Health Integration (GBHI), Community Health Integration (CHI), and more!
    - Beginning in 2024, the G0511 code was finally billable more than once per patient per month

  - The system was becoming a bit unwieldy, and there seemed to be variation in how MACs were operationalizing it
    - It was also impossible to tell which specific care management services were actually being performed and billed

Medicare Care Management Reforms and New Opportunities

- *Finalized*:
  - Allowing RHCs consolidated to bill the **individual CPT codes** on a UB-04 instead of G0511.
  - This includes time based/add-on codes!

Physician Fee Schedule Code	2024 Payment Rate	Short Descriptor		Physician Fee Schedule Code	2024 Payment Rate	Short Descriptor
98975	$19.97	Rem ther mntr 1st setup&edu		99474	$16.64	Self-meas bp 2 readg bid 30d
98976	$47.27	Rem ther mntr dev sply resp		99484	$54.92	Care mgmt svc bhvl hlth cond
98977	$47.27	Rem ther mntr dv sply mscskl		99487	$134.15	Cplx chrnc care 1st 60 min
98980	$50.60	Rem ther mntr 1st 20 min		99489	$72.23	Cplx chrnc care ea addl 30
98981	$39.95	Rem ther mntr ea addl 20 min		99490	$62.58	Chrnc care mgmt staff 1st 20
99091	$53.59	Collj & interpj data ea 30 d		99491	$84.55	Chrnc care mgmt phys 1st 30
99424	$82.55	Prin care mgmt phys 1st 30		G0019	$80.56	Comm hlth intg svs sdoh 60 mn
99425	$59.92	Prin care mgmt phys ea addl		G0022	$50.26	Comm hlth intg svs add 30 m
99426	$61.91	Prin care mgmt staff 1st 30		G0023	$80.56	Pin srv 60 min pr m
99427	$47.27	Prin care mgmt staff ea addl		G0024	$50.26	Pin srv add 30 min pr m
99437	$59.58	Chrnc care mgmt phys ea addl		G0140	$80.56	Nav srv peer sup 60 min pr m
99439	$47.93	Chrnc care mgmt staf ea addl		G0146	$50.26	Nav srv peer sup add 30 pr m
99454	$47.27	Rem mntr physiol param dev		G0323	$54.92	Care manage beh svs 20mins
99457	$48.93	Rem physiol mntr 1st 20 min		G3002	$82.55	Chronic pain mgmt 30 mins
99458	$39.28	Rem physiol mntr ea addl 20		G3003	$30.29	Chronic pain mgmt addl 15m

Medicare Care Management Reforms and New Opportunities

- CMS established a transition period for getting into compliance with the new billing structure.

- From January 1, 2025, through July 1, 2025, RHCs may bill **either** G0511 or the individual CPT codes in this table.
  - This flexibility is at the RHC-facility level as your billing system is updated, however, not the patient level.

- After July 1, 2025, G0511 will no longer be reimbursable.

Advanced Primary Care Management (APCM)

- Alternative, bundled way to provide care management
- Based on levels / number of chronic conditions instead of time
  - Level 1 – zero-one chronic condition – estimated reimbursement $15
  - Level 2 – two chronic conditions – estimated reimbursement $50
  - Level 3 – multiple chronic conditions **and** dual eligible – estimated reimbursement $110

Advanced Primary Care Management (APCM) Elements

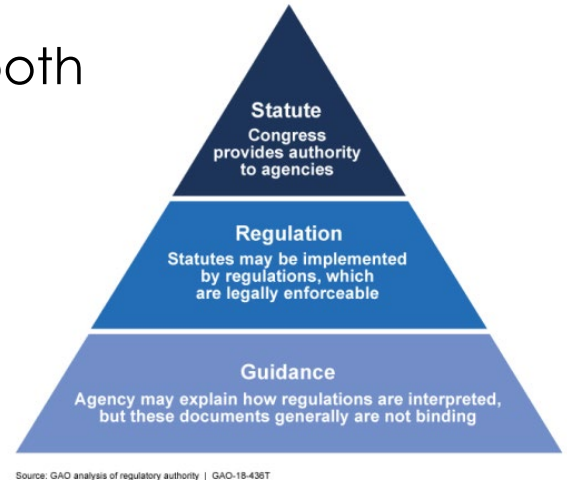
- Patient consent
- Initiation of APCM during qualifying visit (for patients not seen within 3 yrs)
- 24/7 access to a provider/care team
- Continuity of care; patient can schedule routine appts.
- Offer care through alternative modalities (home visits, extended hours)
- Comprehensive Care Management
- Electronic, patient centered care plan
- Coordinated transitions in care and ongoing communication amongst care teams
- Ability to communicate with care team via non-face-to-face methods other than telephone
- Population data analysis
- Risk stratification of patients to determine high-risk patients
- Performance measurement

***Practices must have the capacity to perform all elements, but all elements don't have to be performed monthly.**

***APCM cannot be billed concurrently with CCM, PCM, and TCM codes, but RPM/RTM are separately billable services.**

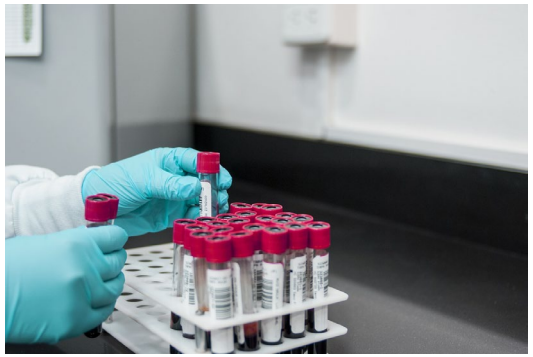
Lab Requirements Changes

- *Currently*:
  - RHC **statute** directs the HHS Secretary to ensure that RHCs provide routine diagnostic services
    - CMS has required via **regulation** that RHCs have the equipment and supplies to offer six specific lab services:
      - chemical examinations of urine by stick or tablet method or both (including urine ketones);
      - hemoglobin or hematocrit;
      - blood glucose;
      - examination of stool specimens for occult blood;
      - pregnancy tests; and
      - primary culturing for transmittal to a certified laboratory.



Lab Requirements Changes

- *Finalized*:
  - CMS removed
    - Hemoglobin and hematocrit (H&H) and
    - Examination of stool specimens for occult blood from the list of required labs
  - CMS also updated "primary culturing for transmittal to a certified laboratory" to "collection of patient specimens for transmittal to a certified laboratory for culturing"



Primary Care versus Specialty Services

- *Currently*:
  - RHC statute and regulation stipulates that RHCs must be primarily engaged in "providing **outpatient** services"
  - However, CMS State Operations Manual Appendix G (guidance) explains that "RHCs may **not** be primarily engaged in **specialized** services"

  - RHCs are currently surveyed to the requirement that more than 50% of their hours must be the provision of **primary** care services

Primary Care versus Specialty Services

- *Finalized*:
  - CMS added the following to the 491.9(2) **regulation**:
    - (i) The clinic or center must provide primary care services.

  - CMS states "we expect RHCs and FQHCs to offer a range of primary health care services to ensure that patients receive the necessary care at the earliest possible point of contact."
  - While CMS is technically *adding* something to the regulation, this is a *decrease* in the restrictive nature of the previously limiting threshold on specialty care to allow for greater flexibility for each individual RHC
  - **Beginning January 1, 2025, instead of being surveyed to the '50% of operating hours must be primary care' standard, RHCs will be surveyed to just providing 'some' primary care services**

Mental Health Services

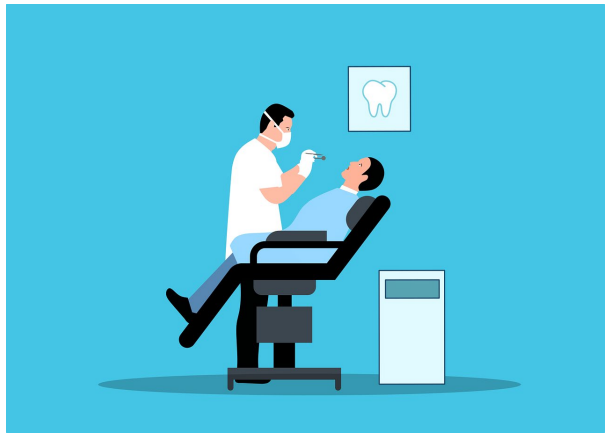
- *Currently*:
  - RHC statute reads that a Rural Health Clinic is "only a facility which... (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases."
  - This has been interpreted to mean that RHCs can only provide up to 49% of their services as behavioral health services
    - However, there is little to no guidance on *how* that 49% should be determined – Diagnosis codes? Types of providers? Services provided? Other?

Mental Health Services

- CMS proposed to define "mental diseases" stating that it is outdated terminology and may have additional negative impacts on stigma and help-seeking behavior
- Many commenters believed that CMS was risking additional unintended consequences by seeking to define such an outdated term
- **CMS withdrew this proposal in the final rule stating that their intention was not to discourage the provision of RHC behavioral health services**

Payment for Dental Services

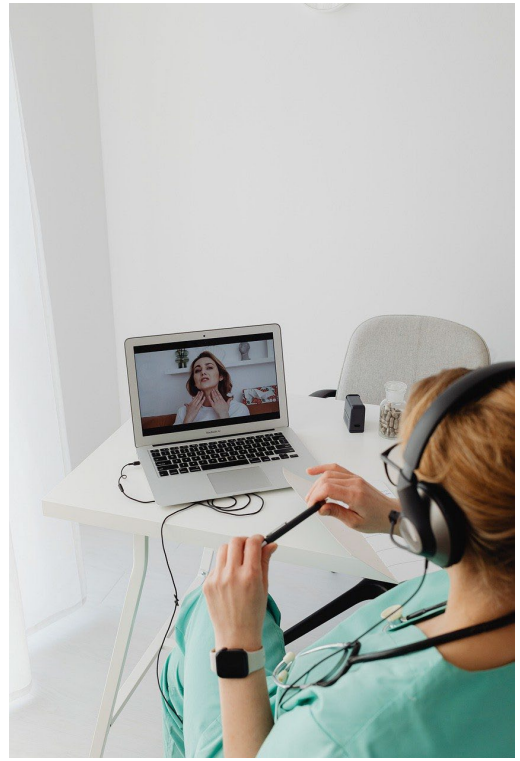
- *Currently*:
  - Medicare is precluded from paying for most dental services. However, exceptions are made for certain outpatient services if the dental service is "inextricably linked to, and substantially related and integral to the clinical success of, other covered services."
  - This exception extends to RHCs, meaning that if the service meets the "inextricably linked" standard and is provided by a dentist in the RHC, it will qualify as an encounter and be paid the RHC's All-Inclusive Rate
- *Finalized*:
  - In this year's final rule, CMS is expanding the list of "inextricably linked" medical services to include dialysis services for beneficiaries with End-Stage Renal Disease (ESRD)
  - The "inextricably linked" dental services are a "dental or oral examination performed as part of a comprehensive workup prior to, and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with" if related to a specific list of conditions
    - RHCs should use modifier KX beginning July 1, 2025
  - **Additionally, CMS finalized that when a medical encounter and a covered dental visit are provided to the same patient in the same day, they are eligible for an exception to the same day visit limitations in RHCs and will be paid as two separate billable encounters**



Intensive Outpatient Program (IOP) Services

- *Currently*:
  - Beginning in 2024, RHCs can furnish Intensive Outpatient Program (IOP) services, behavioral health services intended to serve patients who need care at a level equivalent to 9-19 hours of care per week
  - This reimburses outside of the AIR via a special payment rule
    - This corresponds to approximately three services per patient per day, $259.13 in 2024
  - Others eligible to bill for IOP services can receive either the 3-services-per-day payment rate, or the 4-services-per-day payment rate, depending on the number of services provided, but RHCs and FQHCs are limited to the lower payment rate, regardless of the number of services provided
- *Finalized*:
  - CMS finalized allowing RHCs to bill for the three **or** four services per day IOP, depending on the number of services provided, beginning January 1, 2025.

RHC Telehealth Policy



- *Currently*:
  - Broadly, Medicare medical telehealth flexibilities will expire on December 31, 2024 without Congressional action (who can provide telehealth, where patients can be located, etc.)
- *Finalized*:
  - CMS states: "Eliminating flexibilities under which RHC and FQHC services have been furnished to beneficiaries via telecommunications technology for over 4 years and resuming payment solely for in-person, face-to-face medical visits after December 31, 2024, would cause disruptions in access to services from RHC and FQHC practitioners. This would be particularly problematic for the underserved populations that these settings furnish services to since it could fragment care. We believe that we need to preserve the flexibilities under which RHC and FQHC services have been furnished to beneficiaries via telecommunications technology temporarily and to do so through an approach that these settings are familiar with in order to mitigate burden."

RHC Telehealth Policy

- **On medical telehealth:**
  - CMS is continuing G2025 policy for RHCs, in the absence of Congressional action by December 31
  - "We believe our proposed approach allows us to ensure immediate access to care for beneficiaries currently relying on RHCs and FQHCs while we continue to monitor and analyze information made available to us in order to develop, propose, and finalize more permanent policy in future rulemaking, particularly given the potential for congressional action. **We are therefore finalizing as proposed to continue to pay through CY 2025 for these services furnished by RHCs and FQHCs via telecommunications technology as they have been during and after the PHE through the end of CY 2024; however, we will continue to evaluate and may consider this issue again in future rulemaking."**
  - While this was intended to provide assurance to RHCs/their patients that telehealth flexibilities would not expire in the absence of Congressional action, they did not change originating site policy in this rule (where the patient is located).
    - Therefore, this would revert to limited pre-pandemic rules, again, in the absence of Congressional action, and patients would mostly not be able to access from their homes.
- **On mental health telehealth:** CMS also waived the occasional in-person requirement currently on the books for mental health telehealth through December 31, 2025

DEA Regulations and Telehealth

- The Ryan Haight Act (passed in 2008) requires that before a provider can prescribe certain controlled substances, they need to see the patient in-person (has certain exceptions including a special DEA registration option; DEA never activated this special registration)
- During the COVID-19 pandemic, there have been special waivers to allow providers to prescribe these drugs without an in-person visit
- Latest waiver was supposed to expire December 31, 2024, but DEA recently released another 1-year extension of current flexibilities

Drugs Covered as Additional Preventive Services (DCAP)

- CMS using authority for the first time to cover drugs as "additional preventive services"
- Will cover this at 100% (not 78.4%) of the lesser of the charge or the DCAPS fee schedule
- Creating a specific "DCAPS fee schedule" based on average sale price
- There will initially only be one drug in this category: Preexposure Prophylaxis using approved antiretroviral drugs (oral or injectable) to prevent HIV (also known as HIV PrEP drugs)
  - This was previously covered through Part D and is now shifting to Part B
  - In 2025 should be billable as G0012 (*Injection of pre-exposure prophylaxis (PrEP) drug for HIV prevention, under skin or into muscle*)
  - Payment is going to be approximately $14-$18
  - There are also two other related codes G0011 (which should be billable as an encounter) and G0013 (which will not be billable as an encounter as it does not require a physician or other qualified health professional)
  - https://www.cms.gov/files/document/faq-prep-hiv-06242024.pdf
- CMS could add more drugs in this category over the years through a NCD process
- CMS knows that they will need to provide sub-regulatory guidance on billing details
- CMS confirmed that this will be billed on the UB-04 and pay in addition to the RHC AIR.

Other Regulatory Updates:

- CMS Issues Change Request to Allow CPT Category II Codes to Be Submitted on RHC Claims Beginning April 7, 2025
- Initial Section 1557 requirements kicked in November 2nd
  - Naming of Section 1557 Coordinator (if you have 15+ employees) and Internal Grievance Procedure Development
  - Posting Notice of Nondiscrimination
  - NARHC article with all the details!
- 2025 Medicare Part B Standard Monthly Premium $185
- 2025 Medicare Part B Annual Deductible $257

Other Regulatory Updates:

- Overtime expansion rule struck down by Texas federal judge; applies nationwide
- The rule expanded overtime eligibility for executive, administrative, and professional salaried workers by increasing the threshold required for exemptions, making a much larger population of worker eligible for overtime pay

Questions?

Reminder: To receive your CRHCP CEUs as part of your maintenance requirements, be sure to complete the survey at the end of the webinar!

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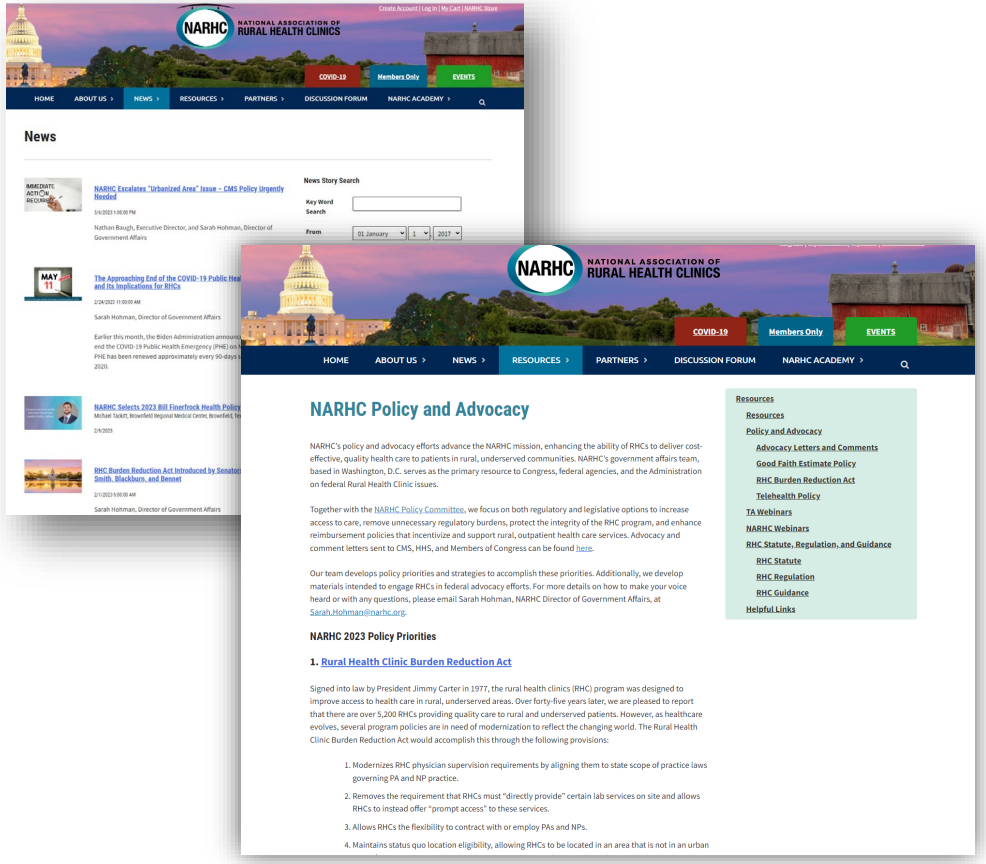

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Questions? Contact us at Academy@NARHC.org

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Sarah Hohman, MPH, CRHCP

Director of Government Affairs

National Association of Rural Health Clinics

202-543-0348
Sarah.Hohman@narhc.org

Nathan Baugh

Executive Director

National Association of Rural Health Clinics

202-543-0348
Nathan.Baugh@narhc.org