Centers for Medicare & Medicaid Services
Open Door Forum: Physicians, Nurses, and Allied Health Professionals
Wednesday, July 19, 2023
2:00-3:00 PM ET

Webinar recording: https://cms.zoomgov.com/rec/share/k7YyiTa9IdyKK-zcb2_xL2mwItr1MVCW_I_M_0x5G_whjKUeo430t1AMmj8uaCkE.MgK0AVO7wXJNbCOq?startTime=1689790095000

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Jill Darling: [Not recorded] *Good morning and good afternoon, folks. We're just going to give it another moment to get some folks in. We appreciate your patience. This is the Physicians Open Door Forum. So please be patient for one more moment until we get some more folks in. Thank you.*
All right, hello and welcome, everyone, to today's Physicians, Nurses, and Allied Health Professionals Open Door Forum. Karen, can you hit record, please? Thank you.

Again, this is the Physicians, Nurses, and Allied Health Professionals Open Door Forum. My name is Jill Darling, and I'm in the Office of Communications here at CMS. Welcome to today's Open Door Forum. As you can see, we are on the Zoom platform. This is our first one for this particular Open Door Forum. So, welcome.

Before we begin, I have a few announcements. This call is being recorded. The recording and transcripts will be available on the CMS Open Door Forum podcast and transcript web page. That link is on the agenda. If you are a member of the press, you may listen in, but please refrain from asking questions during the webinar. If you do have questions, please e-mail press@cms.hhs.gov. All participants are muted. For those who need closed captioning, a link is located in the chat function of the webinar. We will be taking questions at the end of the presentations. You may use the raise hand feature at the bottom of your screen, and we will call on you to ask your question and one follow-up question. And we will do our best to get to as many questions as we can. And now I'll turn the call over to Dr. Gene Freund.

Dr. Eugene Freund: Hi, welcome to our first Zoom Physicians, Nurses, and Allied Health Open Door Forum. A good chunk of this, in fact pretty much all of the presentation, is going to be about the Physicians Fee Schedule proposed rule. Please join me in recognizing all the folks on this call who have been working really hard on this rule, doing great work, and are here to help you understand what's in the proposed rule. Since it's a proposed rule, comments are really important. So, I'll pre-remind you that there's no substitute for submitting formal comments to the rule. Follow the links in the rule text to get to regulations.gov and do that. Without further comment, I want to turn it over to my co-chair, Mr. Gift Tee, who will be leading us through the presentation. Go ahead.

Gift Tee: Thank you, Dr. Freund. And good afternoon, good morning to those of you on the West Coast, thank you for joining us today. Thank you for reading through all 2,000+ pages of the Physician Fee Schedule, and certainly look forward to your comments. Those comments are due by September 11th of 2023, so please don't wait until then to submit. We'll be busy looking through comments this summer, and it will give us a lot of interesting information to consider, I'm sure.

We've got a lot to cover in this Open Door Forum, touching on some of the highlights within our Payment Policies Prospective, and also a couple of policy areas outside of our payment policies. By no means are we covering everything in the rule, so please bear with us as we walk through some of the things we've chosen to highlight. With that, I'll turn it over to my colleague, Morgan Kitzmiller, to kick us off with PFS Rate-Setting/Conversion Factor.

Morgan Kitzmiller: Good afternoon, all. The calendar year 2024 PFS proposed rule includes updates to PFS payments for providers, as required by law. We can calculate the conversion factor using the PFS update adjustment factor, budget neutrality adjustment, and any other statutory updates as required. First, the PFS update adjustment factor for 2024 is 0%, which is specified by the Social Security Act. We also have the negative 2.17% budget neutrality adjustment to account primarily for increases in payment for visits in primary and longitudinal care, which we'll talk about more later. And then lastly, we have the Consolidated Appropriations Act of 2023, which provided a one-time payment increase of 1.25% for services furnished in 2024.

So, after those three adjustments, we're estimating the 2024 conversion factor to be 32.7476, which is a decrease of about $1.14 from the current 2023 conversion factor of $33.89. We estimate the 2024 anesthesia conversion factor to be 20.4370, which reflects the same overall PFS adjustments that we just discussed, with the addition of anesthesia-specific PE and NP adjustments.

Moving on to the clinical labor pricing phase-in. We are not proposing any new changes to the clinical labor rates for 2024, but the 2024 rates differ slightly from the 2023 rates, just because it's the third year of a four-year transition to the updated clinical labor rates.

I think that is all for me, and I'll turn it over to Erick.

Erick Carrera: Thank you. Beginning January 1, 2024, CMS is proposing to implement a separate add-on payment for Health Care Common Procedure Coding System, code G2211. This add-on code would better recognize resource costs associated with Evaluation and Management visits for primary care and longitudinal care of complex patients. Generally, it will be applicable for outpatient office visits, as an additional payment, recognizing the inherent cost clinicians may incur when longitudinally treating a patient's single, serious, or complex chronic condition.

If finalized, we expect the establishing payment for this add-on code would have redistributive impacts for all other calendar year 2024 payments, which comparatively, are less than what we initially estimated for this policy in calendar year 2021 under the Medicare Physician Fee Schedule, due to statutory budget neutrality requirements.

CMS originally finalized this policy in the calendar year 2021 fee schedule final rule. However, Congress suspended the use of the add-on code by prohibiting making additional payment under the PFS for these inherently complex E/M visits before January 1, 2024. Since this policy would improve the accuracy of payment for primary and longitudinal care, CMS is proposing to implement the policy this year.

After considering information from interested parties who shared feedback in earlier rule-making cycles, about utilization assumptions and the estimated redistributive impact of the code on PFS payments, we are proposing refinements. These refinements would reduce the redistributive impacts of the policy. Specifically, we're proposing that the add-on code would not be billed with a modifier, modifier 25, that denotes an office and outpatient Evaluation and Management visit that is, itself, unbundled from another service. That is, a procedure where complexity is already recognized in the evaluation.

Second, we have refined our utilization estimates in response to public feedback, which would collectively reduce the redistributive impact to the calendar year 2024 conversion factor by nearly one-third of the estimated impact described in the calendar year 2021 fee schedule final rule.

With that, I'll pass it on to Sarah Leipnik, my colleague, who will speak about split or shared E/M visits.

Sarah Leipnik: Thank you, Erick. Good afternoon and good morning. I'm going to discuss the policies regarding split or shared services. Split or shared visits refer to an Evaluation and Management visit provided in part by a physician and in part by other nonphysician practitioners in hospitals and other institutional settings.

For calendar year 2024, we are proposing to delay the implementation of our definition of substantive portion as more than half the total time through at least December 31, 2024. Instead, we're proposing to maintain the current definition of the substantive portion for calendar year 2024 that allows for use of either one of the three key components, which are history, exam, or medical decision making, for more than half of the total time spent to determine who bills the visit.

Now going to discuss our policies on promoting health equity under Medicare Part B, which includes services addressing health-related social needs, which are community health integration services, social determinants of health risk assessment, and principal illness navigation services.

For calendar year 2024, CMS is proposing coding and payment changes to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel. These proposed services are in alignment with the HHS social determinants of health action plan and also help to implement the Biden-Harris Cancer Moonshot goal of every American with cancer having access to covered patient navigation services.

Specifically, we're proposing to pay separately and are proposing to create five new G codes for community health integration, social determinants of health risk assessment, and principal illness navigation services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care. While these care support staff have been able to serve as auxiliary personnel to perform covered services incident to the services of a Medicare enrolled billing physician or practitioner, the services described by the proposed G codes are the first that are specifically designed to describe services involving community health workers, care navigators, and peer support specialists.

Community health integration and principal illness navigation services involve a person-centered assessment to better understand a patient's life story, care coordination, contextualizing health education, building patients' health advocacy skills, health system navigation, facilitating behavioral change, providing social and emotional support, and facilitating access to community-based social services to address unmet social determinants of health needs.

Community health integration services are to address unmet social determinant and health needs that affect the diagnosis and treatment of the patient's medical problems. The principal illness navigation services are to help people with Medicare who are diagnosed with high-risk conditions. For example, mental health conditions, substance use disorders, and cancer. Identify and connect with appropriate clinical and support resources. CMS is further clarifying that community health workers, care navigators, peer support specialists and other auxiliary personnel may be employed by community-based organizations, as long as there is requisite supervision by the billing practitioner for these services, similar to other care management services.

I'm now going to turn it over to Maya Peterson to discuss the SDOH social determinants of health risk assessment.

Maya Peterson: Thanks, Sarah. Hi, everybody. In addition to better recognizing costs associated with patient care, access to these services that could contribute to equity, inclusion, and access to care for the Medicare population, and improve the outcomes for the patient, we're looking

specifically to rural health centers, FQHCs, underserved and low-income populations where there is disparity in access to care that Sarah already discussed.

We're also proposing coding and payment for SDOH risk assessment, which is GXXX5, specifically in the PFS, to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the patient.

Additionally, we're also proposing to add this SDOH risk assessment to the annual wellness visit as an optional additional element with an additional payment. Separately, we are also proposing coding and payment for SDOH risk assessments furnished on the same day as an Evaluation and Management visit. I'll now hand off to Mikayla Murphy to discuss caregiver services.

Mikayla Murphy: Good afternoon, everyone. For calendar year 2024, in order to align with the agency's commitment to health equity and the recent Biden-Harris Administration executive order on increasing access to high-quality care and supporting caregivers, we are proposing to make payment for a new code family of caregiver training services. These services describe medically reasonable and necessary training, furnished directly to caregivers, to support patients in carrying out a treatment plan.

We are proposing to pay for these services when furnished by physicians, nonphysician practitioners, which includes nurse practitioners, clinical nurse specialists, certified nurse midwives, physician assistants and clinical psychologists or therapists, which includes physical therapists, occupational therapists, or speech-language pathologists under an individualized treatment plan or therapy plan of care.

I'm going to turn it over to Gift with behavioral health updates.

Gift Tee: Thank you, Mikayla. For CY 2024, we're implementing section 4121 of the CAA, which provides for Medicare Part B coverage and payment under the PFS for marriage and family therapists and mental health counselors, when billed by these professionals. Additionally, we're proposing to allow addiction counselors who meet all of their applicable requirements to enroll in Medicare as mental health counselors.

We're also implementing section 4123 of the CAA, which requires the Secretary to establish new HCPCS codes under the PFS for psychotherapy for crisis services that are furnished in an applicable site of service, which we propose to define as any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, including the home or a mobile unit, furnished on or after January 1, 2024.

The statute requires the payment amount for these psychotherapy services to be equal to 150% of the non-facility rate for the existing CPT codes, describing psychotherapy for crisis, and any succeeding code. Additionally, we are proposing to allow the Health Behavior Assessment and

Intervention, HBAI code, services to be billed by CSWs, MFTs and MHCs, in addition to CPs. Clinical social workers, marriage and family therapists, mental health counselors, and clinical psychologists. We know that under this proposal, the HBAI services must be reasonable and necessary in treatment of illness or injury for a primary diagnosis that is physical in nature.

We are also proposing an increase in the valuation for timed behavioral health services under the PFS. Specifically, we are proposing to apply an adjustment to the work RVUs for psychotherapy codes payable under the PFS, which we are proposing to implement over a four-year transition.

We're also seeking comment on the ways we can continue to expand access to behavioral health services, and are requesting information on digital therapies, including digital cognitive behavioral therapy.

With that, I'll turn it over to my colleague, Kris Corwin.

Kris Corwin: Thanks, Gift. I'll go through our updates for telehealth in general. And first up, we have our annual cycle of review of telehealth services. For calendar year 2024, we're proposing to add health and well-being coaching services to the Medicare telehealth services list, on a temporary basis, and proposing to add, on a permanent basis, the HCPCS code GXXX5, administration of a standardized evidence-based Social Determinants of Health Risk Assessment tool that my colleague Maya Peterson just described earlier.

We further are proposing to refine our process to analyze requests for fees for additional services to the Medicare Telehealth Services List, including a determination if services should be proposed for either permanent or provisional steps.

Additionally, we're proposing to implement several telehealth-related provisions of the CAA 2023, which include a temporary expansion of the scope of telehealth originating sites for services furnished via telehealth, and that includes any site in the United States where the beneficiary is located at the time of receiving the service, which includes an individual home or, further maintaining last year's extended definition of eligible telehealth practitioners to include, qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists.

We're continuing payment for telehealth services furnished via FQHCs and RHCs, using the methodology established for telehealth services furnished by FQHCs and RHCs during the PHE. Delaying the requirement for an in-person visit with the physician or practitioner within six months prior to an initial mental health telehealth service, and similarly again, at subsequent intervals that we described in rulemaking. So again, the in-person requirement for behavioral health telehealth has been delayed by the CAA 2023. And further, we're proposing that for calendar year 2024, claims billed for telehealth provided in the patient's home will be paid at the non-facility Physician Fee Schedule rate to protect access to mental health and other telehealth

services by aligning with telehealth-related flexibilities that were extended via the Consolidated Appropriations Act of 2023.

Amongst our other proposals, we also include to maintain our current policy of virtual direct supervision, which permits the presence and immediate availability of the supervising practitioners through real-time audio and visual interactive telecommunications technology through December 31, 2024. We're soliciting comment on whether we should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024. Specifically, we're interested in input from interested parties on potential patient safety or quality concerns when direct supervision occurs virtually.

In addition to our policies described in this year's proposed rule, we also address telehealth services furnished in teaching settings. As a reminder, in the calendar year 2021 final rule, we established the policy that after the end of the PHE teaching physicians must have physical presence to bill for their services involving residents, including Medicare telehealth services. An exemption was finalized for residency training sites located outside of the metropolitan teaching school area, in which case the teaching physician could be present through audio and video real-time communications technology.

To be consistent with the telehealth policies that were extended under the CAA 2023, we're proposing to allow teaching physicians to use real-time AV communications technology when the resident furnishes Medicare telehealth services in all residency training locations.

The virtual presence would meet the requirements that the teaching physician be present for the key portion of the service through December 31, 2024. We're also seeking comment on a proposal here and namely, what other clinical treatment situations would be appropriate to allow the virtual presence of the teaching physician that we could consider finalizing in the calendar year 2024 Physicians Fee Schedule final rule.

And with that I'll pass it back to my colleague Gift Tee.

Gift Tee: Thanks, Kris. Now I'll cover our supervision policies for physical and occupational therapists in private practice. Since 2005, CMS has required PTs and OTs in private practice to directly supervise their therapy assistants. CMS is proposing a regulatory change to allow for general supervision of their therapy assistants for remote therapeutic monitoring services specifically. We're doing this to align with the RTM general supervision policy that we finalized in our CY 2023 rule making. We're also soliciting comment on whether to revise the current direct supervision regulatory policy for physical and occupational therapists in private practice of their therapy assistants to the general supervision policy for all services and not just for the RTM services.

We're particularly interested in receiving comments, including any available supporting data, on the potential effects of implementing such a policy, including but not limited to patient quality of care, patient safety, and changes in utilization.

This year we're also proposing to amend the regulatory provisions in our regulations, that we established during the CY 2022 PFS rulemaking, to clarify that a registered dietitian or nutrition professional must personally perform MNT services. But the enrolled RD or nutritional professional, when acting as the DSMT or MNT service provider, may bill for on behalf of the entire DSMT entity, regardless of which professional personally delivers each aspect of the service. This proposal, finalized, would build on recent policy changes that we've made, designed to improve access to the Diabetes Self-Management Training Services. We're also advising our regulations, our manual instructions, for DSMT payments, in the medical claims processing manual, which requires one hour of 10-hour DSMT benefits initial training and one hour of the two-hour follow-up annual training to be furnished in-person to allow for corrective injection training when injection training is applicable for insulin-dependent beneficiaries.

And with that I will turn it over to my colleague, Zehra Hussain, to cover our dental and oral health services policies.

Zehra Hussain: Thanks, Gift. Good afternoon, everyone. My name is Zehra Hussain, and I will be discussing dental and oral health services under the PFS. In last year's PFS final rule, Medicare payment, under Parts A and B, could be made when dental services are furnished in either the in-patient or outpatient setting, under particular kinds of circumstances.

Specifically, in CY 2023, CMS finalized, one, our proposal to clarify and codify certain aspects of previous Medicare Fee-for-Service Payment policies for dental services. Two, payment for dental services that are inextricably linked to other covered medical services, such as dental exams, and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures. Three, a process to review and consider public submissions for potentially analogous clinical scenarios under which Medicare payment could be made for dental services. And four, Medicare payment beginning in CY 2024 for dental exams and necessary treatments prior to the treatment for head and neck cancers.

For CY 2024, we are proposing to codify the previously finalized payment policy for dental services prior to or during head and neck cancer treatments, whether primary or metastatic. Additionally, we are proposing to permit payment for certain dental services, inextricably linked to other covered services used to treat cancer, chemotherapy services, (inaudible) cell therapy, and the use of high-dose bone-modifying agents.

These proposals, if finalized, would improve the success of these cancer-related treatments, and increase access to certain dental care in these circumstances. We are also seeking comment on

additional circumstances where evidence supports dental services being integral to the clinical success of covered medical services.

And with that, I will hand it over to my colleague, Adam.

Adam Brooks: Thanks, Zehra. Regarding drugs and biologicals paid under Medicare Part B, the first set of proposals addresses several sections of the Inflation Reduction Act that affect payment limits, or beneficiary out-of-pocket costs, for certain drugs payable under Part B.

In this proposed rule, we address the following: Section 11402, adjusting payment limits for new biosimilars during the initial period when ASP data is not available. Section 11403, addressing Medicare payment for certain biosimilars, which is required to be ASP + 8% rather than 6% of the ASP for the referenced biological for a five-year period defined in the statute. Section 11101, which requires that beneficiary coinsurance for a Part B rebatable drug be based on the inflation-adjusted payment amount if the Medicare payment amount for a calendar quarter the exceeds the inflation-adjusted payment amount, we are proposing conforming changes to regulatory text. And finally, section 11407, which provides that for insulin furnished through an item of DME, the deductible is waived, and coinsurance is limited to $35 for a month's supply of insulin furnished through a covered item of DME.

The second set of proposals, regarding Part B drugs, address the requirement that manufacturers of certain single-dose container or single-use packaged drugs provide refunds with respect to discarded amounts as set forth in the Infrastructure Act. In the calendar year 2023, PFS final rule, we adopted many policies related to this provision. In this proposed rule, we are proposing additional policies, including the timing of the discarded drug refund reports to manufacturers, increased applicable percentages for certain drugs with unique circumstances, and the future application process by which manufacturers may request for a drug to be considered to have unique circumstances, and request an increased applicable percentage.

Lastly, CMS is soliciting comments regarding our policies on the exclusion of coverage for certain drugs under Part B which are usually self-administered by the patient. In addition, we're seeking comment on coding and payment policies for complex, non-chemotherapeutic drugs to promote coding and payment consistency and patient access to infusion services.

And that will do it for me. I'll pass it on to the next speaker.

Rachel Radzyner: Thanks, Adam. This is Rachel Radzyner, and I'll address Medicare Part B payment for preventive vaccine administration services. For this year in CY 2024, we propose that the additional in-home payment for COVID-19 vaccine administration, which was established on a preliminary basis during the COVID-19 PHE, be maintained going forward based on data that show that this payment has helped improve the health care access to vaccines for underserved Medicare populations. CMS is proposing to maintain this additional payment for

administration of a COVID-19 vaccine in the home. CMS is also proposing to extend this in-home additional payment for the administration of the other three, Part B preventive vaccines and provide them in the home. And those are, the pneumococcal, influenza, and hepatitis B vaccines.

Now I'll pass it on to the Medicare Shared Savings Program speakers.

Fiona Larbi: Thank you and good afternoon. My name is Fiona Larbi, and I'll be going over the proposals for the Medicare Shared Savings Program. The CY 2024 Physician Fee Schedule proposed rule includes proposed changes to the Medicare shared savings program to further advance CMS's overall value-based care strategy of growth, alignment, and equity and to respond to concerns raised by council care organizations and other interested parties. These proposed changes include incremental refinement to the broader changes finalized in the calendar year 2023 Physician Fee Schedule final rule.

We propose changes to continue to move ACOs toward digital measurement of quality by establishing a new Medicare clinical quality measure (CQM) collection type for ACOs under the alternative payment model performance pathway. We are also proposing additional refinements to the financial benchmarking methodology for ACOs, and agreement periods beginning on January 1, 2024, and subsequent years, to acquire a symmetrical cap to risk score growth in an ACO's regional service area, similar to the cap applied on ACOs' risk score growth. Apply the same CMS hierarchical condition category, CMS takes the risk adjustment methodology to both the benchmark and performance years, and further mitigate the impact of the negative regional adjustments on the benchmarks to encourage participation by ACOs caring for medically complex, high-cost beneficiaries.

Additional proposals include adding a third step to the step-wide beneficiary assignment methodology to provide greater recognition of the role of nurse practitioners, physician assistants, and clinical nurse specialists in delivering primary care services, and updates to the definition of primary care services used for purposes of beneficiary assignments to remain consistent with billing and coding guidelines as well as assignments to policies for the newly established advanced investment payments.

In addition, we seek comment on potential future developments for the Shared Savings Program policies, including incorporating a new track that would offer a high level of risk and potential reward than currently available under the in-house track. Refining this three-way blended benchmark update factor and prior savings adjustment and promoting ACO and community-based organization collaboration.

Thank you. And I'm handing it back to Jill now.

Jill Darling: Wonderful. Thank you, Fiona, and thank you to all of our speakers. Now we're going to go into Q&A. So, if you do have a question, please use the raise hand feature at the bottom and we will call on you. Please have one question and one follow-up. Thank you. We'll give it a moment.

Karen Mohr: Toya, you may unmute and ask your question.

Toya Campbell: Yes, hi. Good afternoon. My question is specific to telehealth services. The language in the Consolidated Appropriations Act of 2022 and 2023 temporarily expanded the definition for telehealth-eligible practitioners. And I noticed that in the proposed rule calendar year 2024 proposed rule, there's only mention of the physical therapist, speech-language pathologist, and occupational therapist, as well as audiologists that are mentioned. In the FAQs that were issued by CMS on October 13 of 2022, in January 1 of 2021, CMS specifically states that auxiliary personnel who cannot bill Medicare for their services were able to bill incident to as telehealth. Just seeking clarification on that.

Kris Corwin: Thanks for your question, Toya. If you could send that to MedicarePhysicianFeeSchedule@cms.hhs.gov. I want to make sure that we understand the full scope of your question, because there's a difference between incident to billing, for certain types of practitioners, and use of auxiliary personnel. So, I want to make sure that I don't infuse the intent of your question. But I'm happy to take it offline and answer it further.

Toya Campbell: Okay. Will do. Thank you.

Karen Mohr: Edmond, you may unmute and ask your question. Edmond, you may unmute and ask your question.

Edmond Cabbabe: Okay. Hi. This is Edmond Cabbabe. I'm a plastic surgeon in St. Louis. And I'm the guy behind the assistant physician. You know, assistant physicians and graduate physicians now are laws in about eight states. There are physicians who graduated from medical school. Sometimes with internships, some time, but they do not qualify for a license because they don't have residency under their arms. Now, private insurance and Medicaid are reimbursing for their services. They serve in underserved areas under supervision of a physician. They have a lot more education than nurse practitioners or physician assistants. However, Medicare still will not pay for their services.

What is the way to do it to get Medicare to do that?

Gift Tee: Dr. Cabbabe, thank you for your question. If you wouldn't mind submitting that to our mailbox, we'll take that offline. I think there's a lot of consideration, as you point out, including our statutory authority, and what allows certain practitioners to bill Medicare directly. But, certainly happy to see your question in writing.

Edmond Cabbabe: Great. Thank you very much.

Karen Mohr: Joy, you may unmute and ask your question.

Joy Chen: Hi, thank you. So, my question is on the new G-code, G2211, for visit complexity. Can that code be billed with the E/M codes that are routinely used for, let's say, established patients in the home?

Erick Carrera: So, at this time, we are not proposing that G2211 would be payable for established visits in the home. G2211 would be payable, as we finalized in calendar year 2021, for office outpatient E/M codes 99202 through 205, and 99211 through 215.

Joy Chen: Thank you.

Karen Mohr: Carolyn, you may unmute and ask your question.

Carolyn Dean: Hello. This is Carolyn Dean of Matrix Care. I have a question on the CAA of 2023 provision that allows the two new discipline categories to be covered under the hospice benefit, the NFT, and the other therapists for behavioral health. And my question is specific to if these new services were the CRPs for hospice are being proposed to allow these new entities, these new categories, to be part of the hospice interdisciplinary team, if they're covered under hospice bundled services, or paid separately, under Medicare Part B, that's my first question. I wasn't really understanding the proposal in the rule as related to these two new COPs for these two new discipline services that can now be, you know, part of the hospice IDG team. So that's my first question.

Gift Tee: Hey, Carolyn. Thank you for the question. I think we want to see that in writing, if you wouldn't mind submitting to our MedicarePhysicianFeeSchedule@cms.hhs.gov mailbox, we'll take a look. I hear you say hospice, and part of that care setting, and we're not sure we have the right people on here to talk about it from that perspective. What I did discuss, or at least what I referenced, was the idea that to require for the creation of these two new specialties or at least recognizing those two categories of clinicians as billing practitioners under Part B, but it would help us to take a closer look at your question to see if we can answer it more.

Carolyn Dean: Okay. Earlier you did address the other CAA 2023 provisions, but not the one specific to hospice coverage, and the two CRPs that were proposed. So, I'll submit that in writing to the physicians…?

Gift Tee: Yes, the medicarephysiciansfeeschedule@cms.hhs.gov.

Carolyn Dean: Okay, thank you.

Gift Tee: It sounded like you had a second question?

Carolyn Dean: It would be a follow-up to that based on your answer to that as to how those services are covered under the hospice benefit, then would be how would they be reported, if at all, on claims.

Gift Tee: Okay. Understood. Thank you.

Carolyn Dean: Thank you.

Karen Mohr: Kay, you may unmute and ask your question. Kay, are you able to unmute and ask your question?

Kay Moyer: Hello.

Karen Mohr: Yes, we hear you.

Kay Moyer: Hi, great. Thank you. My question is, my name is Kay Moyer from CRD Associates. I wondered if you could clarify for me regarding telehealth services that are not behavioral health services, that are billed between January 1 and December 31 of 2024, with the place of service to, will be paid at the non-facility rate. It's not clear…

Kris Corwin: I can confirm that is in our proposal. That it should be, as proposed. I'll go back and look and check. But please do comment if it's not clear in the rule to you, as well, please.

Kay Moyer: Correct. So that's what I'm—when I read it, it seems that you could bill those, even if they're not behavioral health. And they'll be paid at a non-facility rate. Thank you for that clarification.

Karen Mohr: Susan, you may unmute and ask your question.

Susan Hurowitz: Hi. Thank you. Regarding behavioral health, and the providers eligible 1124 under the proposal to bill independently, I just wanted to clarify that included an LSW, an LCSW, an LMFT, and the master's level psychologist. And when can they actually start to apply for their Medicare numbers?

Gift Tee: Thanks, Susan. If you wouldn't mind sending that question to the mailbox, we'll take a look.

Susan Hurowitz: The Medicarefeeschedule@CMS.hhs.gov mailbox?

Gift Tee: Yes.

Susan Hurowitz: Okay. Thank you.

Karen Mohr: Mary, you may unmute and ask your question.

Mary Rossi-Coajou: Thank you. So, I'm actually responding to the question that was asked on the hospice changes. So, I worked with the conditions of participation here at CMS. So, at this point, the mental health counselor and the marriage and family therapist would be paid as part of bundled services or bundled payment that hospice received, and there is no specific item on the claims form at this time. Thanks.

Karen Mohr: Mubarak, you may unmute and ask your question.

Mubarak: Hi, everybody. CMS has done a wonderful job, and I am the council member, state of Illinois, and I encourage all of you, that you are looking for all of the professionals and trying to give us independence. My question is, what about the physical therapists? All of the insurances, they recognize them as independent. CMS does not recognize them as independent practitioners. So, what is the update on that?

Gift Tee: Thank you for your question, sir. CMS follows statute as defined in the law, and that law does point out or identify the practitioners that may bill Medicare directly. And so, we do—we do abide by those specific requirements and implement those requirements. You asked about physical therapists, specifically, correct?

Mubarak: Yes. Yes.

Gift Tee: Well, physical therapists in private practice, I believe, are allowed to bill Medicare directly. Are you talking about other types of therapists in different settings?

Mubarak: No. They do bill directly. But they cannot see the patients directly without a doctor referral.

Gift Tee: Okay. Understood. If you wouldn't mind submitting your question through the mailbox, so that we can take a deeper dive into the question.

Mubarak: All right. Will do. Thank you.

Karen Mohr: Diane, you may unmute and ask your question.

Diane Cardwell: Yeah. This is Diane Cardwell. And I'm working at practices in the Primary Care First initiative. So, as you think about the G codes for the additional SDOH, have you

considered that not falling under the flat visit fee, under the Primary Care First model of payment, they're paid the population-based payment and then flat visit fee? The challenge of some of those things that flow with the AWV is they're all clumped into one flat visit fee. Has that been considered?

Gift Tee: Thanks for your question, Diane. We don't have colleagues from our Primary Care First model development team on here. But we can certainly share with them and work through your question. So go ahead and submit to the Medicare Physician Fee Schedule mailbox, as well, too, please.

Diane Cardwell: Great, thank you, yeah. Because a lot of times what's happening is they're spacing those out on different days, because that's the only way they can get appropriate reimbursement for it, which is inconvenient for staff, inconvenient for patients. So, something to consider. Thanks.

Gift Tee: Thank you.

Karen Mohr: Are there any additional questions?

Jill Darling: I see another hand.

Karen Mohr: Carol, you may unmute and ask your question.

Carol Yarbrough: Hi there. I did submit a question via e-mail, but perhaps you can go into some details during this meeting. Carol Yarbrough from UCFS Health. Wondering if that non-facility fee for place of service 10 is also applicable to place of service—or HOPDs, or physician-based hospital practices since we're no longer billing G0463 or Q3014. Thank you.

Gift Tee: Hi, Carol. I think that's another one that we'll have to take a closer look at. That crosses over into our OPD space. Just want to be able to make sure we answer correctly. Go ahead, please submit your question. And I think you just said you submitted your question to our mailbox.

Carol Yarbrough: I did. Yeah, thank you, Gift. Appreciate it.

Gift Tee: Thank you.

Karen Mohr: Jeffrey, you may unmute and ask your question.

Jeffrey Davis: Hi, this is Jeffrey Davis. This is a quick question for Gift. For table 104 of the rule which had the specialty impacts. I want to confirm this does not include the CAA 2023

1.25% reduction as part of the conversion factor. Is that correct? Or just the budget neutrality impact?

Gift Tee: Hey, Jeff. We'll confirm and we'll get back to you.

Jeffrey Davis: Thanks.

Karen Mohr: Mary, you may unmute and ask your question.

Mary Waldo: Thank you. I was wondering if somebody could speak to the enrollment of a physician's home address if they're providing telehealth from their homes? And if that's something that we're going to have to do. Whether they work 100% from their home, versus maybe partially from their home and partially from the office.

Gift Tee: Hi, Mary. We're getting a lot of incoming on that specific question, so we're working with our enrollment colleagues to figure out a path forward, so stay tuned.

Mary Waldo: Thank you.

Karen Mohr: Christie. You may unmute and ask your question.

Christie Sheets: Thank you so much. I'm just curious to know, for the misvalued codes for therapy providers, how long are you going to be giving the RUC to review this?

Gift Tee: That's a great question, Christie. As you point out, we did discuss in the rule, there is some consideration for what that means for payment for '24 and going forward, but we do not control the RUC. I'm sure they're reviewing and thinking about what their opportunities are to react to the information we provided. I guess I'm saying stay tuned.

Christie Sheets: At the mercy of the RUC. Thank you.

Jill Darling: All right, everyone. I don't see any more hands raised. So, I'll hand it back to Gene.

Dr. Eugene Freund: Thank you. And thanks to all of you for joining the call for the great questions, and for commenting. Thank you in advance for getting comments in about the rule during the comment period. And with that, we can end, unless, Gift, you have anything to add?

Gift Tee: No, Dr. Freund. Thank you. Thank you, as always.

Dr. Eugene Freund: Thank you all for attending.