

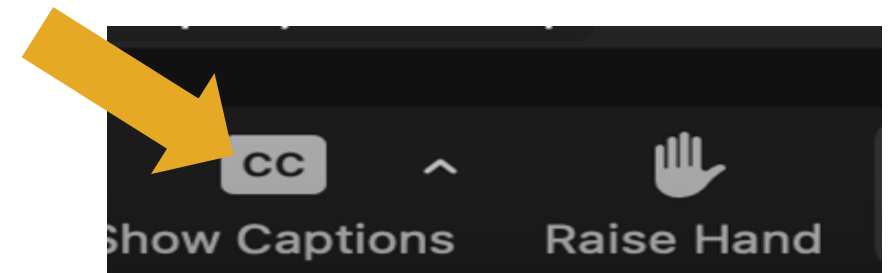
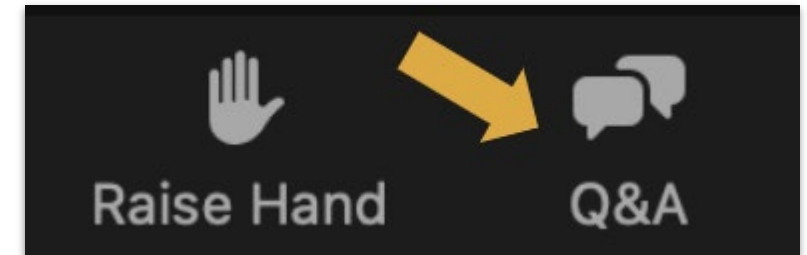
What Does the CY2025 Physician Fee Schedule Mean for Addressing HRSNs?

July 30, 2024

2:00-3:30 p.m. ET

Administrative Notes

- ✓ This webinar is being recorded. The recording, slides, and follow-up material will be shared with all registrants
- ✓ Please use the Q&A tab at the bottom of your screen and we'll try address as many questions as possible at the end of the presentation
- ✓ Closed captions are provided for this session, can also click "Show Captions" to display automated captions



Partnership to Align Social Care

Mission:

To enable successful **partnerships** and contracts **between health care and community care networks** to **create** efficient and sustainable **ecosystems** needed to provide **individuals with holistic, person-centered social care** that demonstrates cultural humility.

Vision:

A **sustainably resourced, community-centered social care delivery system** that is **inclusive** of all populations and **empowered by shared governance** and financing, multistakeholder accountability, and federal/state/local policy levers.

Co-Designing a Social Care Delivery System



Implementing Co-Designed Social Care Delivery System Changes





CY 2025 Medicare Physician Fee Schedule

- **Unpublished draft released 7/10:** <https://www.partnership2asc.org/wp-content/uploads/2024/07/CY-2025-PFS-Unpublished-Version-7.10.24.pdf>
- Comments due **September 9**
- **Issue areas Partnership is reviewing:**
 1. Request for Information Regarding CHI, PIN, and SDOH Risk Assessment Services
 2. Additional Advanced Primary Care Management Services and Request for Information
 3. Updates to Caregiver Training Services
 4. Revised Payment Policies for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) Delivering CHI/PIN Services
- **Broad stakeholder engagement including:**
 - Informational webinar and additional calls
 - Partnership sign-on letter
 - Template letter(s)

July 30 Agenda

1. Abbreviated Review of the CY2024 PFS Rule for CHI / PIN / PIN-PS
2. CHI / PIN Request for Information
3. Advanced Primary Care
4. Caregiver Training
5. ACO Quality Measure

Brief Overview:
Community Health Integration (CHI),
Principal Illness Navigation (PIN),
PIN-Peer Support (PIN-PS),

CMS CY2024 Physician Fee Schedule

- Landmark Final Rule creates the first of its kind pathway for reimbursement for Community Health Worker labor in the Medicare program.
- **Effective Date: January 1, 2024**
- Part B benefit which applies to persons in **Original Medicare, MA, & Special Needs Plans**
- Applies to all Medicare Part B providers – including FQHCs & RHCs
- National Policy that is independent of any State Medicaid Waiver initiatives

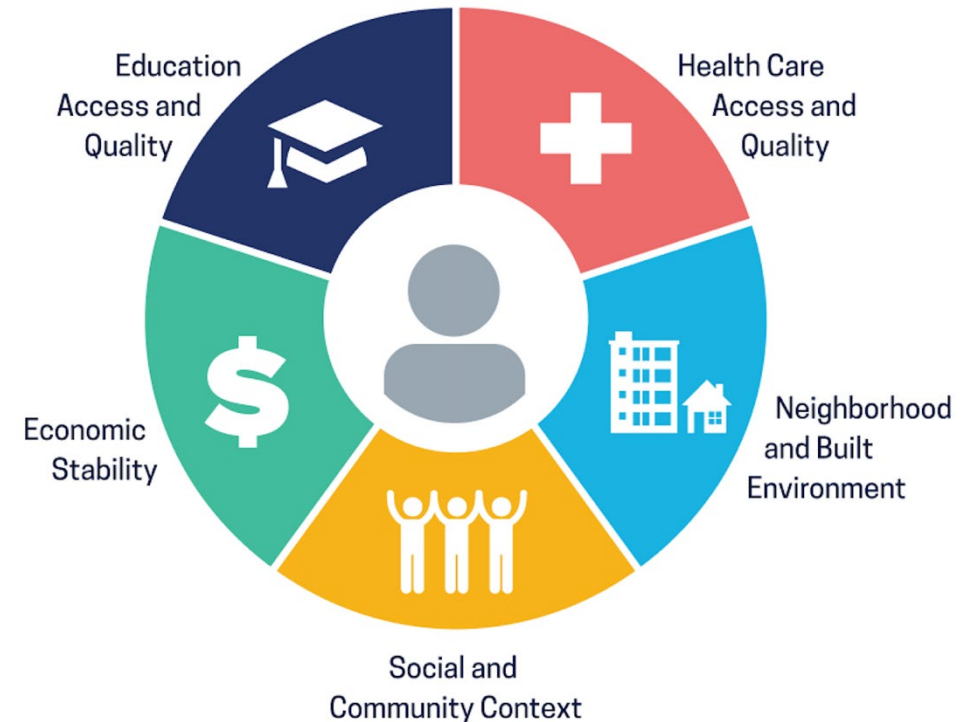
New HCPCS Billing Codes for Labor to Address HRSNs

Community Health Integration (CHI)

Reimbursement for labor expended for **addressing Health-Related Social Needs (HRSNs): Food, Housing, Transportation, Utility Difficulty, Interpersonal Safety, Etc.**

Personnel: Community Health Workers, Health Coaches, Social Workers, RDs, Nurses, and other staff with applicable training.

Social Determinants of Health



New HCPCS Billing Codes for Health Navigation Labor

Principal Illness Navigation (PIN)

Reimbursement for providing **health navigation services** for persons with a **serious, high-risk condition that will last at least 3 months.**

Personnel: Community Health Workers, Navigators, Health Coaches, Social Workers, RDs, Nurses, other staff with applicable training.



New HCPCS Billing Codes for Peer Support Services

Principal Illness Navigation – Peer Support (PIN-PS)

Reimbursement for providing **Peer Support Services to persons with a behavioral health or SUD.**

Personnel: Trained Peer Support Workers.



Community Health Integration

- Definition:
 - SDOH(s) may include but are not limited to food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities, **when they significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the CHI initiating visit.**
- Requires the following:
 - Consent
 - Initiating Visit
 - General Supervision of auxiliary personnel performing incident to services.

CMS Policy Supports Provider Contracting with CBOs

- **Community Care Hub**
 - Network of CBOs organized into a social care delivery system.
- **Other CBOs**
 - Area Agencies on Aging (AAAs),
 - Centers for Independent Living (CILs),
 - Community Action Agencies,
 - Local Health Departments
 - Housing Agencies,
 - Aging and Disability Resource Centers (ADRCs), or
 - **other non-profits that perform social services.**

Co-Insurance Waiver Policy

- Effective for dates of service on or after January 1, 2011, Medicare will provide 100 percent payment (in other words, will waive any coinsurance or copayment) for the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and for those preventive services that: **1) Are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population;** and 2) Are appropriate for the individual.

US Preventive Task Force

- Website: <https://www.uspreventiveservicestaskforce.org/uspstf/>
- In order to Waive the Co-insurance, the US Preventive Task Force must issue a Grade A or B for the service.
- There must be scientific evidence to support the issuance of a Grade A or B recommendation.

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Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

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Level of Certainty*	Description
<p>→ High</p>	<p>The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.</p>
<p>→ Moderate</p>	<p>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as:</p> <ul style="list-style-type: none"> • The number, size, or quality of individual studies. • Inconsistency of findings across individual studies. • Limited generalizability of findings to routine primary care practice. • Lack of coherence in the chain of evidence. <p>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</p>
<p>Low</p>	<p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> • The limited number or size of studies. • Important flaws in study design or methods. • Inconsistency of findings across individual studies. • Gaps in the chain of evidence. • Findings not generalizable to routine primary care practice. • Lack of information on important health outcomes. <p>More information may allow estimation of effects on health outcomes.</p>

*The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net

Co-Insurance

- What is Co-Insurance?
- Answer, HealthCare.Gov: <https://www.healthcare.gov/glossary/co-insurance/>

Co-insurance

- The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.
- Let's say your health insurance plan's allowed amount for an office visit is \$100 and your coinsurance is 20%.
- If you've paid your deductible: You pay 20% of \$100, or \$20. The insurance company pays the rest.
- If you haven't met your deductible: You pay the full allowed amount, \$100.

Medicare Out-of-Pocket Expenses

- Medicare Costs
- Available Online: <https://www.medicare.gov/basics/costs/medicare-costs>



Part B (Medical Insurance) costs

Part B costs:	What you pay in 2024:
Premium	<p>\$174.70 each month (or higher depending on your income). The amount can change each year. You'll pay the premium each month, even if you don't get any Part B-covered services.</p> <p>Who pays a higher Part B premium because of income? ⓘ</p> <p>You might pay a monthly penalty if you don't sign up for Part B when you're first eligible for Medicare (usually when you turn 65). You'll pay the penalty for as long as you have Part B. The penalty goes up the longer you wait to sign up. Find out how the Part B penalty works and how to avoid it.</p>
Deductible	<p>\$240 before Original Medicare starts to pay. You pay this deductible once each year.</p>
General costs for services (coinsurance)	<p>Usually 20% of the cost for each Medicare-covered service or item after you've paid your deductible (and as long as your doctor or health care provider accepts the Medicare-approved amount as full payment – called "accepting assignment"). Find out how assignment affects what you pay.</p>

Co-Insurance & Secondary Coverage

- In order to reduce out-of-pocket expenses, many Medicare beneficiaries enroll in a Medicare Advantage Plan or obtain a Medicare Supplement or Medigap policy.
- If a beneficiary is a dual-eligible (Medicare + Medicaid) then Medicaid becomes the secondary policy.

Breakdown of Coverage

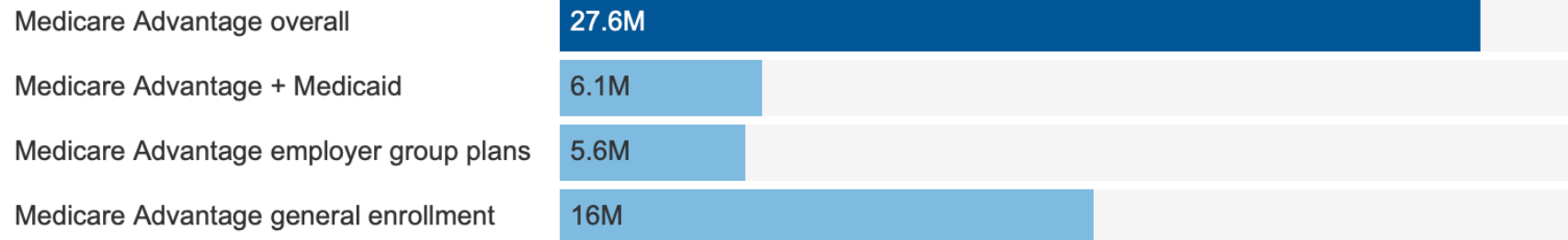
- Kaiser Family Foundation. A Snapshot of Sources of Coverage Among Medicare Beneficiaries. Available online:
<https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>
- Findings:
 - “Nearly all People with Medicare Had Coverage Either Through Medicare Advantage Plans or Traditional Medicare Coupled with Some Other Type of Coverage in 2021.

Figure 1

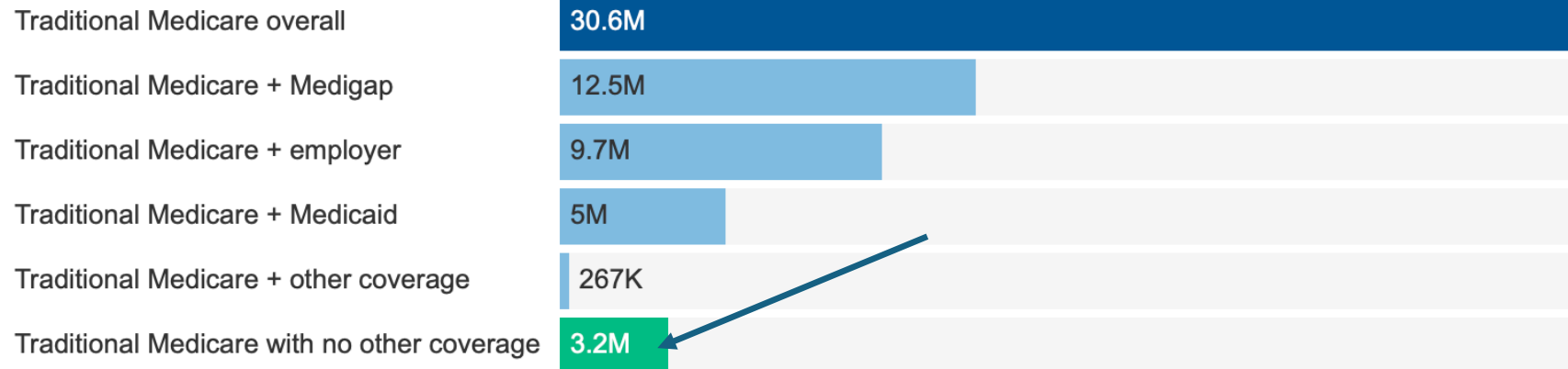
Nearly all People with Medicare Had Coverage Either Through Medicare Advantage Plans or Traditional Medicare Coupled with Some Other Type of Coverage in 2021

Three Million Medicare Beneficiaries in Traditional Medicare Had No Additional Coverage in 2021

Medicare Advantage



Traditional Medicare



NOTE: Total excludes beneficiaries with Part A only or Part B only for most of the year (n=5.0 million) or Medicare as a Secondary Payer (n=1.6 million).

SOURCE: KFF analysis of CMS Medicare Current Beneficiary Survey, 2021 Survey File. • [PNG](#)

Percentage of the Population with Traditional Medicare and No Other Coverage

Total Population Based on Kaiser Family Foundation Analysis (2021)

- 27.6 M Enrolled in a MA Plan
- 30.6 M Enrolled in Traditional Medicare
- Total = 58.2 Million

- Traditional Medicare with no other coverage = 3.2 M
- Percentage with no secondary coverage for Co-insurance expenses = 5.49%
- Percentage of Population with Medicare + Other Insurance = 94.51%

CHI • PIN • PIN-PS

Request for Information (RFI)

Request for Information: CHI / PIN / PIN-PS / SDOH Risk Assessment

Purpose of the RFI:

- Seeking comment on any related services that may not be described by the current coding.
- There is an opportunity to explore additional opportunities to create codes that describe reasonable and necessary services **furnished by billing practitioners and the auxiliary personnel under their general supervision.**
- Feedback on any barriers to furnishing services.
- Do the services that are described by the codes allowing practitioners to better address unmet social needs.
- Are there other types of auxiliary personnel furnishing these services and the level of training that they may have.

Clarification of Auxiliary Personnel

“the codes do not limit the types of other health care professionals, such as registered nurses and social workers, that can perform CHI services (and PIN services) incident to the billing practitioner’s professional services, so long as they meet the requirements to provide all elements of the service included in the code, consistent with the definition of auxiliary personnel.”

Examples

- Clinical Social Workers
- Registered Nurses
- Registered Dietitians

Barriers Specific to Certain Populations

- Rural
- Tribal Communities
- Residents of U.S. Territories
- Island Populations
- Individuals with Disabilities
- Individuals with Limited English Proficiency
- Other Populations

Underserved Communities

“Are there nuances or considerations that CMS should understand related to auxiliary personal and training, certifications or licensure barriers or requirements that are **specifically experienced by practitioners serving underserved communities.**”

Setting

Are there barriers specific to the following settings:

- FQHCs
- RHCs
- Tribal Health Centers
- Migrant farmworker clinics
- Facilities located in and serving rural and geographically isolated communities.

CBO Collaborations

- We [CMS] are interested in **hearing more about CBOs and their collaborative relationships with billing practitioners.**
- We [CMS] are seeking comment regarding the **extent to which practitioners are contracting with CBOs** (including current or planned contracting arrangements) **for auxiliary personnel purposes**, and if there is **anything else CMS should do to clarify services** where auxiliary personnel can be employed by the CBO, so long as they are under the general supervision of the billing practitioner.

Incident To Construct

- We [CMS] are seeking comment on **whether the incident to billing construct is appropriate for CBOs** to supplement pre-existing staffing arrangements and the CBO/provider interface.
- We [CMS] are seeking comment on **CBOs' roles**, the **extent to which practitioners are contracting with CBOs**, **incident to billing**, and **auxiliary personnel employed by CBOs under general supervision** of practitioners serving and located in **rural, Tribal and geographically isolated communities**, including the US Territories.

Additional RFI Questions

- We [CMS] are requesting information on **anything else that we should consider in the context of these codes and what else we could consider to be included** in this newly established code set.
- We [CMS] are **seeking comments on ways to identify specific services and to recognize possible barriers to improved access** to these kinds of services.

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Advanced Primary Care

New Codes for Advanced Primary Care

- CMS is proposing to establish new coding and payment policy to recognize advanced primary care management (APCM) services for use by practitioners who are providing services under a specific model of advanced primary care, when the practitioner is the continual focal point for all needed health care services and responsible for all primary care services.

Advanced Primary Care RFI

- CMS is seeking input on an Advanced Primary Care Hybrid Payment.
- The Advanced Primary Care payment would include a bundle of services with an emphasis on coordinating care.
- Questions:
 - Would The Advanced Primary Care Management payment be duplicative of CHI, PIN, and other care management services?
 - Should a bundled payment for Advanced Primary Care Management include CHI & PIN?

FQHC & RHC Payment Method for Care Management Services

Proposed CY2025 Change for FQHCs & RHCs

- New Codes for Advanced Primary Care Management Services (APCM) applicable to Federally Qualified Health Centers and Rural Health Centers (FQHCs and RHCs).
- The proposed coding for APCM incorporates elements of several existing care management services into a bundle to be paid separately to RHCs and FQHCs using code G0511.

FQHCs & RHCs billing for CHI & PIN

- CMS proposes that FQHCs & RHCs, when furnishing APCM to use the three (3) codes created for the PFS (G-codes).
- Payment would be at the non-facility rate.
- Billing would occur per calendar month bundles.
- Would be paid separately from RHC AIR or FQHC PPS payment.

Direct Caregiver Training Services (CTS)

Direct Caregiver Training Services

- Proposed New HCPCS Codes for Direct Caregiver Training Services
- GCTD1: Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control (without the patient present) face-to-face; initial 30 minutes.

Direct Caregiver Training Services (GCTD2)

- Proposed New HCPCS Codes for Direct Caregiver Training Services
- GCTD2: Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control (without the patient present) face-to-face; each additional 15 minutes.

Direct Caregiver Training Services (GCTD2 & GCTD3)

- Proposed New HCPCS Codes for Direct Caregiver Training Services
- **GCTD2:** Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control (without the patient present) face-to-face; each additional 15 minutes.
- **GCTD3:** Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face with multiple sets of caregivers.

Individual Behavior Management/Modification Caregiver Training Services

- Proposed New HCPCS Codes for Direct Caregiver Training Services
- GCTD1 & GCTD2
- Caregiver training in behavior management/modification for caregiver(s) of a patient with a mental or physical health diagnosis, administered by physician or another qualified health care professional (without the patient present), face-to-face; initial 30 minutes.
- GCTD2: each additional 15 minutes.

New ACO Quality Measures for SDOH

ACO Quality Measure Proposed Rule

For ACO Performance Year 2028 and Subsequent Performance Years (Highlighted Changes)

- Initiation and Engagement of Substance use Disorder Treatment
- Screening for Social Drivers of Health

Implementation Resources

- Partnership CHI/PIN Implementation Resources and Events:
<https://www.partnership2asc.org/implementation-resources/>
- Freedmen's Health Consulting Implementation Resources:
<https://communityintegration.info>
- Free Implementation Resources including:
 - Sample Contract Agreement (Clinic – CBO)
 - Sample Process Flows
 - Partnership to Align Social Care CHI/PIN Implementation Primer

Next Steps

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Questions

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Thank You!

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