

Centers for Medicare & Medicaid Services  
Physicians, Nurses and Allied Health Professionals Open Door Forum  
Thursday, November 7, 2024  
2:00 – 3:00 p.m. ET

Webinar recording: [https://cms.zoomgov.com/rec/share/PPG-WU0BRu12XCz\\_HEUFjZ58j1GIWmDCAL8W9EqlixhBHMEU7DDSRBkOSTFOC7X9.bvkb2RfYYKpznxhW](https://cms.zoomgov.com/rec/share/PPG-WU0BRu12XCz_HEUFjZ58j1GIWmDCAL8W9EqlixhBHMEU7DDSRBkOSTFOC7X9.bvkb2RfYYKpznxhW)  
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**Jill Darling:** Great, thank you so much. Good morning and good afternoon, everyone. My name is Jill Darling, and I'm in the CMS Office of Communications, and welcome to today's Physicians, Nurses and Allied Health Professionals Open Door Forum (ODF). Before we begin our agenda, I have a few announcements. For those who need closed captioning, I provided a link in the chat, and I can provide it again throughout the webinar if needed. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum Transcript web page, and that link was on the agenda, and I'll share it with you in the chat. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email [press@cms.hhs.gov](mailto:press@cms.hhs.gov). All participants are muted upon entry. For today's webinar, I will have the agenda slide up for you. And then we will be taking questions at the end of the agenda today. We note that we will be presenting and answering questions on the topics listed on the agenda. We ask that any live questions relate to the topics presented during today's call. If you have any questions unrelated to these agenda items, we may not have the appropriate person on the call to answer your question. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the ODF resource mailbox that I will provide and that is also listed on the agenda, and we'll get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we will call on you when it's time for Q&A. Please introduce yourself with your organization or business you are calling from. And when the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question, and we'll do our best to get up to all your questions today. So now, I will turn the call over to our chair, Gift Tee.

**Gift Tee:** Thanks, Jill. Good afternoon, and good morning, if you're on the West Coast. As Jill said, appreciate your attendance to this Open Door Forum this afternoon. There's a lot of work that CMS has been doing over the last several months that has culminated in the release of several final rules. Today we are focused on the CY 2025 Physician Fee Schedule (PFS) final rule, and just a disclaimer, as I think I mentioned at all of these meetings, we are only covering several topics, not all of the topics, in the rule, but the team—the teams—that are on here have done amazing work in just putting a lot of stuff together and of course, they appreciate your patience with them as they've been working on the rules and not necessarily working on the rules and answering all of the questions that are important to address. So, they will get back to addressing a lot of those questions that they've put down to focus on getting the rules out. But the rules are out, and they are here today to cover some of the topics in the rule. And so, with that, I will turn it over to our first speaker today to cover updates on some of the work that our

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colleagues in the Office of Burden Reduction have been leading. So, I think I'm turning over to Jon.

**Jon Langmead:** Yes. Hi, hi. Thank you very much. Hi, everybody. My name is Jon Langmead. I am with the CMS Office of Burden Reduction, focused on health care experience, interoperability, and as is in our name, burden reduction. I'm really happy to be here with you today. I'm going to take just a minute to be sure that everybody here is aware of the upcoming 2024 CMS conference on Optimizing Health Care Delivery to Improve Patient Lives, which is taking place on Thursday, December 12 from 11:00 a.m. to 4:00 p.m. Eastern Time. This is a free, 100% virtual conference that CMS hosts. It's going to be our second—our second conference focused on optimizing health care delivery and reducing administrative burden. And as we did at the conference last year, we're going to be convening members from all parts of the health care community and the federal government and all aspects of government to share new ideas, lessons learned, and best practices to reduce administrative burden and strengthen access to safe, quality care.

We have a fantastic agenda planned for this year. Our keynote speaker is Dr. Jonathan Perlin, who is the President and Chief Executive Officer at the Joint Commission. We also have a whole list of guests—great speakers lined up, including a number of speakers from CMS, including our Deputy Administrator, Jon Blum, as well as Dr. Ed Long from New York City Health and Hospitals, Amanda Aguirre from the Regional Center for Border Health in Arizona, Nate Apathy from University of Maryland School of Public Health, and Kelly Cronin with the Administration for Community Living. So, we really pulled together a diverse group of people to talk about what they're doing, and again, to expand access to care and reduce administrative burden. You can register for the conference. You can also see the full list of our confirmed speakers, and you'll soon have an agenda up at [cmsburdenreductionconference.com](https://cmsburdenreductionconference.com). And I'm going to put that link in the chat in just a second. But again, it's [cmsburdenreductionconference.com](https://cmsburdenreductionconference.com). You can also see videos from last year's conference at the website to kind of get a flavor of what we talked about last year. We're going to be building on all those ideas, as well as increasing our focus on best practices and lessons learned, focusing again on reducing administrative burden, and really hear from people, what's working for them in the community, maybe what's maybe not working. What lessons are they learning? And what are the pain points that they're focusing on? We had a great turnout last year, and we're hoping to continue to grow our reach, so we hope you'll join us. I also hope you'll consider sharing the link with anyone in your organization or anyone really that you work with that you think might be interested. A reminder that the conference is free. It's 100% virtual. And you can go to [cmsburdenreductionconference.com](https://cmsburdenreductionconference.com) to register and see all of our great speakers. And with that, thank everybody for your time today, and I will turn it back over to Jill.

**Jill Darling:** Great. Thank you, Jon. Next, we'll be getting into the updates of the calendar year 2025 Physician Fee Schedule final rule. And first up, we have Michael.

**Michael Soracoe:** All right. Thank you, Jill. So, I'm here to cover the rate setting and conversion factor associated with the Physician Fee Schedule. So, this is always something that attracts a lot of attention. People want to know, what does our conversion factor look like? As a refresher, the conversion factor is how we translate relative value units, or RVUs, into dollars. And there are a

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couple of different things that go into it each year. The first is if we have any statutory updates affecting the conversion factor. We do not have any for 2025. It is 0% statutory update factor. We also are required by statute to have a budget neutrality adjustment each year to the conversion factor. As many of you know, if there's any spending that exceeds \$20 million threshold, we have to make adjustments to preserve budget neutrality. After we went through and calculated our budget neutrality adjustment for 2025, we ended up with a very small positive adjustment, which was 0.02, so that's 1/50<sup>th</sup> of 1%. As I said, it was very small. Similar to what we had projected in the proposed rule where we had projected 0.05, we ended up at 0.02 in the final rule, so we were very close to what we had projected. And then the other thing that affects the conversion factor, which is the biggest thing affecting it, is for the current year 2024, there is currently a 2.93% increase to the conversion factor that is scheduled to expire at the end of 2024. However, because it was a one-year provision only, so we have calculated the 2025 conversion factor without a 2.93% in place. So, after adjusting for the very small budget neutrality adjustment and the removal of that 2.93%, we have a conversion factor of \$32.3346, so about \$32.33, and that is a decrease of 94 cents or about 2.8% from the current conversion factor, which is \$33.29. Again, the main thing is the 2.93% that is going away at the start of 2025. With that in mind, I will now turn it over to my colleague, Emily Yoder, who is going to cover telehealth.

**Emily Yoder:** Thank you so much, Michael. So yes, I'll be kicking us off with the discussion of Medicare telehealth services paid under the Physician Fee Schedule. So, we are finalizing our proposal to add caregiver training services to the Medicare telehealth list provisionally, and we're also permanently adding HIV PrEP (Pre-Exposure Prophylaxis) counseling and safety planning interventions as well. We are finalizing to continue the suspension of frequency limitations for certain services for calendar year 2025. We are finalizing that an interactive telecommunication system may include two-way, real-time, audio-only communication technology for any Medicare telehealth service furnished to a beneficiary in their home if the distant site practitioner is technically capable of using but the patient is not capable of or does not consent to the use of video technology. We are finalizing for a certain subset of services that are required to be furnished under the direct supervision of a physician or practitioner to permanently adopt a definition of direct supervision that allows virtual presence through real-time audio and video. For all other services requiring direct supervision, we are finalizing to continue to permit direct supervision to be provided through real-time audio and video only through December 31, 2025. And lastly, we are also finalizing a policy to continue to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings but only in clinical instances when the service is furnished virtually. And again, this is through December 31, 2025.

Moving along to a couple of other PFS updates that I'll be covering. So, for the office/outpatient evaluation and management (E&M) complexity add-on code for 2025, we are finalizing our proposal to allow payment of this office/outpatient E&M visit complexity add-on code when the office visit base code is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any other Medicare Part B preventive service. And finally, I will be covering briefly the Advanced Primary Care Management (APCM) services. So, we are finalizing our proposal to establish coding and payment under the PFS for a new set of APCM services described by three new HCPCS (Health Care Common Procedure Coding System) G

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codes, which incorporate elements of several existing care management and communication technology-based services into a bundle of services that reflect the essential elements of the delivery of advanced primary care. And in response to comments, we are also finalizing an increase in the valuation for the level one of these three new codes. And with that, I will be handing it to Mikayla for Million Hearts.

**Mikayla Murphy:** Hi, good afternoon, everyone. The CMS Innovation Center tested the Million Hearts Model, which coupled payments for cardiovascular risk assessment with cardiovascular care management. It was found to reduce the rate of death by lowering heart attacks and strokes among Medicare fee-for-service beneficiaries. In order to incorporate these lessons learned and increase access to these lifesaving interventions, in this final rule, we finalized coding and payment for a cardiovascular risk assessment service and risk management service. The risk assessment will be performed in conjunction with an E/M visit when a practitioner identifies a patient at risk for cardiovascular disease who does not currently have a diagnosis of cardiovascular disease. The standardized, evidence-based risk assessment tool used needs to include demographic data, modifiable risk factors for cardiovascular disease, which could include blood pressure, cholesterol control, smoking status, alcohol and other drug use, physical activity and nutrition and obesity, possible risk enhancers, and laboratory data. The output of this tool must include a 10-year estimate of the patient's cardiovascular disease risk. We also finalized coding and payment for cardiovascular risk management services, and that service needs to include elements related to the ABCS of cardiovascular risk reduction, which stands for aspirin use, blood pressure management, cholesterol management, and smoking cessation, if needed. And this service is for beneficiaries at intermediate, medium, or high risk in the next 10 years for cardiovascular disease as determined by the risk assessment. Thank you, and I'm going to turn it over to Sarah.

**Sarah Leipnik:** Thank you, Mikayla. Good afternoon and good morning. I'm Sarah Leipnik, and I'm going to discuss the policies regarding strategies for improving global surgery payment accuracy. For 2025, we finalized the policy to broaden the applicability of the transfer of care modifier, modifier 54, for all 90-day global surgical packages in any case when a practitioner expects to furnish only the surgical portion or the surgical procedure portion of the global package, including but not limited to when there is a formal documented transfer of care as under current policy or an informal non-documented but expected transfer of care. This finalized policy will improve payment accuracy for these 90-day global package services, and it is expected to inform CMS about how global package services are typically furnished. For calendar year 2025, we also finalized a new add-on code, HCPCS code G0559, for postoperative care services furnished by a practitioner other than the one who performed the surgical procedure or another practitioner in the same group practice. This add-on code will more appropriately reflect the time and resources involved in these postoperative follow-up visits by practitioners who were not involved in furnishing the surgical procedure. I'm now going to turn it over to Michelle Cruse to discuss dental and oral health services. Michelle?

**Michelle Cruse:** Thanks, Sarah. Hello, I'm Michelle Cruse, and we'll discuss dental and oral health services. For 2025, we are amending our regulations by adding to the list of clinical scenarios under which fee-for-service Medicare payment may be made for dental services inextricably linked to covered services to include dental or oral examination in the inpatient or

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outpatient setting prior to, or contemporaneously with, dialysis services for the treatment of end-stage renal disease and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, dialysis services for the treatment of end-stage renal disease. We are also finalizing two billing requirements with a delay that is effective July 1, 2025. We will require the submission of the KX modifier on institutional physician and dental claim formats for dental services that clinicians believe to be inextricably linked to covered medical services, and we will require the submission of a diagnosis code on the dental claim format. This ends my presentation on dental services, and I will turn it over to Pam to discuss the next topic. Thank you.

**Pam West:** Thank you, Michelle, and good afternoon, everyone. I am Pam West, and I will be discussing two issues today. The first issue relates to revised supervision policy in private practices. For calendar year 2025, we finalized regulatory changes to allow for general supervision of therapy assistants by physical therapists (PTs) and occupational therapists (OTs) in private practice. This will align with the general supervision of therapy assistants by PTs and OTs working in institutional providers. We believe this will allow for greater flexibility in meeting patients' need and safeguard patient access to medically necessary therapy services, including those furnished in rural and underserved areas.

The second issue relates to new certification policy for therapist established treatment plans. In— for calendar year 2025, to lessen the administrative burden for therapists and physicians and certain non-physician practitioners, we finalized amendments in the regulatory provision for certification requirements of therapy treatment plans. These changes provide a regulatory exception to the signature requirement of the physician or non-physician practitioner on the initial certification of a therapist established treatment plan. This exception is only applicable to those cases in which the physician or non-physician practitioner order or referral is on file and the therapist has documented evidence that they've transmitted the treatment plan to that physician or non-physician practitioner within 30 days of their initial evaluation.

As part of rulemaking, we also solicited comment as suggested by interested parties as to the need for a regulation to address the amount of time during which the physician or non-physician practitioner who signed the written order or a referral for therapy services could make changes to the therapist's established treatment plan by contacting the therapist directly, but we did not adopt such a time restriction. Instead, we clarified that for the cases needing the exception to the signature requirement policy or for cases without an order or referral for those treatment plans submitted to the physician or non-physician practitioner with knowledge of the case, that payments should be made available for therapy services furnished prior to a physician modified treatment plan if all other payment requirements, including medical necessity, are met. Lastly, we did not adopt a policy for the common solicitation as to whether there should be a 90-day or other limit to the physician or non-physician practitioner order extending from the date—order date to the first date of treatment or evaluation by the therapist. And now I'll turn the mic over to Lindsey Baldwin.

**Lindsey Baldwin:** Great, thanks so much, Pam. Hi everyone, this is Lindsey Baldwin, and I will cover the behavioral health topics in the final rule. We're finalizing several actions to help support access to behavioral health in line with the CMS Behavioral Health Strategy. For CY

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2025, we're finalizing separate coding and payment under the Physician Fee Schedule describing safety planning interventions for patients in crisis, including those with suicidal ideation or at risk of suicide or overdose. Specifically, we're finalizing payment for a G code that may be billed in 20-minute increments when safety planning interventions are personally performed by the billing practitioner in a variety of settings. Additionally, we're finalizing payment for a monthly billing code that requires specific protocols in furnishing post-discharge telephonic follow-up contacts that are performed in conjunction with a discharge from the emergency department for a crisis encounter as a bundled service describing up to four calls in a calendar month.

To further support access to psychotherapy, we are finalizing Medicare payment for digital mental health treatment devices cleared by the FDA (Food and Drug Administration) and furnished incident to professional behavioral health services used in conjunction with ongoing behavioral health care under a behavioral health plan of care. CMS is finalizing three new HCPCS codes to describe these services, and we will monitor how digital mental health treatment devices are used as part of overall behavioral health care. We're also finalizing six G codes to be billed by practitioners and specialties whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, which includes clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors that mirror current interprofessional consultation CPT (Current Procedural Terminology) codes used by practitioners who are eligible to bill for E/M visits. And with that, I will pass it to my colleagues in DAS (Division of Ambulatory Services) to cover policies related to Part B drugs. Thanks so much.

**Adam Brooks:** Thanks, Lindsey. My name is Adam Brooks, and I'll be kicking off topics related to drugs separately payable under Part B. First, CMS finalized an approach to how it will calculate payment limits when manufacturers report negative or zero ASP (Average Sales Price) data to CMS. Generally, we're finalizing a policy that negative and zero ASP data is considered not available under section 1847A of the Act and that positive ASP data is considered available. The finalized policies determine a payment limit when ASP data is not available vary based on factors about the drug or biological such as whether the drug is a single source or multiple source drug, whether some but not all NDCs (national drug codes) for a billing and payment code have a negative or zero—zero—ASP data, or all NDCs for billing and payment code have a negative zero ASP data, and whether relevant applications for all NDCs for a billing and payment code have a marketing status of discontinued. Altogether, CMS finalized its policies for calculating the payment limit when a manufacturer reports negative or zero ASP data for a drug with a modification relating to biosimilars such that the finalized payment limit calculation will use the biosimilar's own most recently available positive manufacturer's ASP data.

Moving on to immunosuppressive therapy. Because some people rely on compounded immunosuppressive drugs for maintenance therapy, we finalized provisions to regulations to include certain compounded formulations of FDA approved drugs that have approved immunosuppressive indications and the immunosuppressive drug benefit, or for use in conjunction with immunosuppressive drugs, or that have been determined by a MAC (Medicare Administrative Contractor) to be reasonable and necessary to prevent or treat rejection of a transplanted organ or tissue. Specifically, we finalized inclusion of certain compounded formulations that are orally or enterally administered. In addition, we finalized two changes

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regarding supplies of immunosuppressive drugs to align with current standards of practice and reduce barriers to medication adherence, to allow payment of the supplying fee for a prescription of the supply of up to 90 days, and to allow payment for refills of prescriptions for these immunosuppressive drugs. Now on to my colleague, Jae.

**Jae Ryu:** Hello, my name is Jae. I'll be discussing four clarifying policies on discarded drugs that we finalized. First, the definition of a single-dose container includes drugs in ampules and drugs with a volume less than two mL that lack packaging type terms or discard statement. Second, four drugs subject to a national coverage determination. The start date of the 18-month exclusion will be the date of the first Part B payment for the drug. Third, the use of the JW modifier is required when a billing provider does not administer the drug but discards a portion during preparation. Lastly, skin substitutes will not be counted as refundable drugs for the 2025 calendar quarters. I'll turn over the mic to Becky.

**Becky Ray:** Thanks, Jae. This is Becky Ray, and I'll be covering the last two policies under Part B drugs. The first policy is payment for radiopharmaceuticals in the physician office setting. CMS finalized a clarification that any payment methodology that was being used by any MAC prior to the enactment of the MMA (Medicare Modernization Act) can continue to be used by any MAC, including the use of invoice-based pricing. That is, we are clarifying that any methodology that was in place to set pricing of radiopharmaceuticals in the physician office setting prior to November 2003 can be used by any MAC, whether or not that specific MAC used the methodology prior to November 2003. And a second policy I'll be covering is blood clotting factors. CMS finalized an update to regulatory text to clarify existing CMS policy that blood clotting factors must be self-administered and must not be therapies that enable the body to produce clotting factors and do not directly integrate into coagulation cascade to be considered clotting factors for which the furnishing fee applies. That concludes Part B drug policies, and I'll hand it over to Rachel for preventive services.

**Rachel Radzyner:** Thanks, Becky. My name is Rachel Radzyner, and I'll be discussing several proposals related to preventive services. First, for CY 2025, we finalized two items related to the hepatitis B vaccine and its administration. In another part of this rule, we finalized a proposal to expand coverage of hepatitis B vaccinations, and accordingly, we also clarified that a physician's order would no longer be required for the administration of hepatitis B vaccine in Part B. This will—this will—facilitate roster billing by mass immunizers for hepatitis B vaccine administration. We're also finalizing a policy that allows payment for hepatitis B vaccines and their administration to be made at 100% of reasonable costs in RHCs (Rural Health Clinics) and FQHCs (Federally Qualified Health Centers) in order to streamline payment for all Part B vaccines in those settings.

Second, we're proposing a fee schedule for Drugs covered as Additional Preventive Services, or DCAPS drugs, for short. CMS had not covered or paid for any drugs under the benefit category of additional preventive services until CMS recently released a final NCD (national coverage determination) regarding Part B coverage for PrEP for HIV drugs on September 30, 2024. So, in this final rule, we finalized the proposal to determine a payment limit for DCAPS drugs according to ASP methodology set forth in section 1847A of the Act. And that's when ASP data is available for those drugs. In cases when ASP data is not available, we finalized alternative

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payment mechanisms for calculating payment limits for DCAPS drugs. In addition, we finalized payment limits for the supply and administration of DCAPS drugs which are similar to those for other Part B drugs. And finally, we said that the same fee schedule for DCAPS drugs would apply to RHCs and FQHCs. In RHCs and FQHCs, DCAPS drugs and any admin and supply fees will be paid at 100% of the Medicare payment amount and will be paid on a claim-by-claim basis separate from the FCHC PPS (Prospective Payment System) and the RHC all-inclusive rate. And now I'll pass it to Ariana Pitcher. Thank you.

**Ariana Pitcher:** Hi everyone. I'll be covering new policies finalized for opioid treatment programs (OTP). So, first CMS finalized several telehealth flexibilities for opioid use disorder (OUD) treatment services furnished by OTPs as long as these services are permitted under all applicable requirements at the time the services are furnished. We are allowing periodic assessments to be furnished via audio-only telecommunications on a permanent basis and allowing the OTP intake add-on code to be furnished via audio video telecommunications for methadone treatment initiation if the OTP determines that an adequate evaluation of the patient can be accomplished. Additionally, in response to recent regulatory reforms finalized by SAMHSA (Substance Abuse and Mental Health Services Administration), CMS is updating payment for intake activities and periodic assessments furnished by OTPs to include payment for social determinant of health risk assessments. We believe these updates will support OTPs to identify a patient's unmet health-related social needs or the need and interest for harm reduction interventions and recovery support services that are critical to the treatment of an OUD. And after receiving detailed supportive comments in response to a request for information in the proposed rule to understand how OTPs currently coordinate care and make referrals to community-based organizations, CMS finalized three new add-on codes to account for coordinated care and referral services, patient navigational services, and peer recovery support services. We believe these services are integral to efforts to address unmet needs across the continuum of care and connect patients to support services that will assist them in achieving treatment and recovery goals. And finally, CMS finalized payment for a new FDA-approved nalmefene hydrochloride nasal spray and a new FDA-approved injectable buprenorphine product. And that is it for OTPs. I believe I'm passing it to Joseph to cover the Medicare Shared Savings Program. Thank you.

**Joseph Otto:** Thank you, Ariana. My name is Joe Otto, and I'm covering the Medicare Shared Savings Program on policies that were updated in the calendar year 2025 PFS to further advance Medicare's value-based care strategy of growth, alignment, and equity. The Shared Savings Program, as of January 1, 2024, had 480 ACOs (Accountable Care Organizations) that were included in the program, providing care to more than 10.8 billion assigned beneficiaries. ACOs are now delivering care to nearly 50% of people with traditional Medicare, and in the calendar year 2025 PFS, we build upon policies that were finalized in the 2023 PFS and 2024 PFS that are expected to further drive growth and participation in the Shared Savings Program and are central to achieving CMS' goal of having 100% of people with traditional Medicare in a care relationship with accountability for quality and total cost of care by 2030. In the 2025 PFS, CMS finalized policies to establish a new, prepaid shared savings option to encourage investments by eligible ACOs that have a history of earning shared savings, such as investments in direct beneficiary services and investments to improve care coordination through enhanced staffing or health care infrastructure.

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We also finalized changes to the Shared Savings Program's financial methodology to encourage ACO participation in the Shared Savings Program by increasing incentives to enter and remain in the program through the application of a health equity benchmark adjustment. Additionally, we finalized several policies to align quality measure reporting with the adult and Universal Foundation measures and promote digital quality measure reporting. To improve the accuracy, fairness, and integrity of the Shared Savings Program financial calculations, we finalized the methodology to account for the impact of improper payments in recalculating performance year and benchmark year expenditures used in financial reconciliation upon the reopening of a payment determination. We also adopted a methodology for excluding payment amounts for codes exhibiting significant anomalous and highly suspect billing activity during calendar year 2024 or subsequent calendar years that warrant adjustment. In addition to these policies, we summarized comments received in response to the comments solicitation that sought to gather information on financial arrangements that could allow for higher risk and potential reward than are currently available under the enhanced track in the Shared Savings Program. And let me turn it over to Katie Moore to talk more about our Quality Payment Program.

**Kati Moore:** Great, thanks Joe. Good afternoon, everyone. As Joe said, I'm going to cover our Quality Payment Program (QPP) policies. I'm just going to hit some high-level points we wanted to flag for everyone today, but wanted to make sure you knew that next Thursday, November 14 at 1:00 p.m., we are hosting a QPP specific webinar to go into all of our finalized policies in greater detail. So, I will put the link for registration to that in the chat. And we also have a QPP specific fact sheet that we will go into a lot more detail than I'm going to cover today. So, I encourage folks to go to the QPP resource library and check that out as well if you haven't quite gotten through our thousand pages rule, which is completely understandable. So just real quick to highlight. So, we finalized policies that really focus on maintaining stability within the Merit-based Incentive Payment System, or MIPS. We're looking to continue the development and maintenance of our MIPS value pathways, or MVPs. We established the Alternative Payment Model Performance Pathway Plus, so our APP Plus quality measure set and then made a number of updates to our MIPS measures and activities inventories as well as some updates to our scoring methodologies. So more specifically, we finalized to maintain performance threshold at 75 points, which is where it's at for the 2024 performance year using the mean of 75 points from our calendar year 2017 performance period and 2019 payment year continues to be the most feasible option for us to keep that performance threshold down a little bit. We're also maintaining the 75% data completeness criteria through 2028 performance period. And then back to our MVPs, we finalized six new MVPs to be available in 2025. Complete ophthalmological care MVP, dermatology care, gastroenterology optimal care for patients with urological conditions, pulmonology, and surgical care MVP. And then we also made slight modifications to the current 16 MVPs that are in our inventory, including a consolidation of, we had two neurology focused MVPs, so we're combining them into a single neurological MVP, which will bring our total to 21 MVPs available for 2025. So, we're really excited about that. We're going to continue building on that inventory going forward as well.

And then as mentioned earlier, we did finalize an additional quality measure set under the APP called the APP Plus, really to offer clinicians to participate in a MIPS APM (Alternative Payment Model) more robust opportunity for MIPS quality measurement. The APP Plus is

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comprised of 11 measures consisting of the six measures in the existing APP quality measure set, five of which are adult Universal Foundation measures, five additional measures from that foundational measure set. These measures will be incrementally incorporated over time more gradually than we had originally proposed.

And then lastly, just wanted to highlight that we finalized our proposal to apply an alternative benchmarking methodology to a subset of our topped out measures that belong to specialty sets that really have limited measure choice. And there's a high proportion of their measures that are topped out in areas that really lack measure development, which really precludes people from meaningful participation in MIPS. So, we're trying to address that issue and then we will propose the measures that will apply to that policy each year through rulemaking. So that will continuously change. And with that, I'm going to put these links to the fact sheet and the webinar in the chat, but I will turn it back over to Jill to get us going with the Q&A. Thanks.

**Jill Darling:** Thank you, Kati. And thank you to everyone for speaking today, and like Kati said, we will be getting into our Q&A. So, reminder to please use the raise hand feature at the bottom of your screen to get in the queue and please have one question and a follow up.

**Karen Mohr:** Great, so we see Renee Watson—you may unmute and ask your question.

**Renee Watson:** Hey. Renee Watson. I am a family physician in Smithfield, North Carolina. I have an independent, rural-based office. I do telehealth in my family practice. And my understanding is that as of January 1, telehealth as we've been doing it through the COVID years will no longer be paid for. We will not be able to do telehealth through on our regular Medicare patients. Can someone speak about that?

**Emily Yoder:** Sure thing, Renee. That's a great question. So, this is Emily Yoder, and that is somewhat correct in that the statutory waivers that have been in place on the geographic and site of service and practitioner type restrictions that are in the statute, those will, unless there is late breaking legislation this year, those will go back into effect on January 1, 2025. In terms of, and I recognize that those are, some of those are primarily, I imagine what you're asking about. I will say that to the extent to which CMS has regulatory authority to address other aspects of the telehealth flexibilities, we have extended a lot of things for an additional year or made a few things that we could permanent. So, but you're right, absent congressional action, the geographic inside of service restrictions will go back into effect.

**Renee Watson:** As a...do I get a follow-up question?

**Emily Yoder:** Go ahead.

**Renee Watson:** As someone in rural North Carolina, we've come to use telehealth in multiple ways. I believe it's probably an underused service since the pandemic is over, but we use it to help with our Medicare wellness exams to help with our depression screenings to help reach out to people who have difficulties in transportation getting to the physician's office. What can I do as a practitioner? Do I need to lobby congressman? Is there a way that Congress can change what's changing? How can we make sure we hold on to telehealth? I think it's a useful tool and

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we are expected to go through a lot of quality measures and get them things done for the patients and we use telehealth to help attain those quality measures in discussing things with patients that they need to do and have performed. So, what can I do? What can we do as physicians to hold onto this telehealth benefit for our patients, which I believe is beneficial?

**Emily Yoder:** Yeah, so I do want to clarify that although the, I mean telehealth is available without any kind of waiver for beneficiaries that are in rural areas. Now your specific practice, I know that the definition of rural that I don't have off the top of my head is very specific and so I recognize that it does not always capture other rural patients outside of the very specific definition that is in the statute. So, I do just want to flag that the beneficiaries who meet the definitions of rural for purposes of the telehealth statute can continue to receive some telehealth services. Although unless it's a behavioral health service, they would need to be in a medical facility to receive that service, and they're not in their home. In terms of what you can do, I don't think that CMS is in the position of being able to tell you what you can and cannot do vis-a-vis Congress. But I would note that these types of changes to the statute would need to come from congressional action. There's nothing that CMS, we can do necessarily to advocate it beyond just noting that that is what it would require. I'm sorry, I know that that is kind of a technocratic answer, but that is sort of as far as we can go as an agency in terms of telling you sort of what you need to do.

**Lindsey Baldwin:** And I would just add one other thing. This is Lindsey Baldwin and DPS (Division of Practitioner Services). In order to find out if you are in a health professional shortage area, if you're not sure about that, there is a tool on HRSA's (Health Resources and Services Administration) website that you can look up and check to see if you would qualify for continued use of telehealth following the ending of the waivers.

**Renee Watson:** Yes, Lindsey, I know that I'm in a health—in a rural area—because we put the AQ modifier on and we, our county hospital, a small county hospital, had all that evaluation done. And so, we get that AQ modifier added. But what happens with CMS and what happens with red, white, and blue Medicare typically now happens with the Medicare Advantage programs. And so, I see telehealth going away nationwide, and I just think it's a mistake. I think it's a useful service and it's a mistake to take that away. And I didn't like it when it first came on and COVID came on. I thought it was frustrating. Now I find it a very useful tool, so I thank you for your answers.

**Lindsey Baldwin:** No, thank you so much for that feedback. We really appreciate it.

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

**Chantel Susztar:** I apologize. I was raising my hand to make you aware that one of the speaker's audio was tremendously low and it wasn't for getting into the queue for a question. Thank you. Thank you.

**Karen Mohr:** Let's see, Leila, you may unmute and ask your question. Leila Bishop?

**Leila Bishop:** Yes, mine was the same as the previous. I was raising my hand to let you know. I couldn't hear the one speaker. It wasn't a question. I thought I could chat and type it in to let you guys know. It was hard to hear.

**Karen Mohr:** Thank you so much. OK, next. Valerie Rinkle, you may unmute and ask your question.

**Valerie Rinkle:** Thank you. My question concerns caregiver training services in the MPFS (Medicare Physician Fee Schedule) final rule. The answer came with regard to the CPT (Current Procedural Terminology) codes for caregiver training services that the services could be billable by physicians and practitioners, incident-to. So, in a non-facility setting, a practitioner's able to bill when auxiliary personnel incident to their professional services perform caregiver training services. And my question is, does that extend to the new HCPC (Healthcare Common Procedure Coding) level two codes that CMS finalized for caregiver training services in this rule? And then I have a follow up after that.

**Mikayla Murphy:** Hi Valerie, this is Mikayla Murphy. Yes, the auxiliary personnel designation does apply to all the caregiver training service codes, not just the CDT or HCPC systems, but all of them.

**Valerie Rinkle:** OK, great. And you are very faint in your audio. So, my follow-up question is given that and thank you so much and I think that's great news for physician practices and necessary caregiver training services. I'm confused then, and I know this is a Physician Fee Schedule call, but I'm very confused about the policy for those same codes over in the outpatient Prospective Payment System rule where the status indicator is A, and CMS says they're only billable by hospitals when performed by therapist. So, it means that a physician cannot order auxiliary hospital personnel at a hospital to do caregiver training services for the patients that they're treating. And that seems inconsistent to me. Can you speak to that?

**Mikayla Murphy:** If you could send that question specifically in writing just to one of the emails, then I can discuss that. That would be a cross-component discussion. So, if you could send that in writing, that'd be very helpful. Thank you.

**Valerie Rinkle:** OK.

**Karen Mohr:** OK. Jody Holden, you may unmute and ask your question. Jody, you may unmute and ask your question. All right. We'll circle back to Jody. Marilyn Martin, you may unmute and ask your question.

**Marilyn Martin:** Good afternoon. Can you hear me?

**Karen Mohr:** Yes, we can.

**Marilyn Martin:** Awesome. Thank you for taking my question. I'm Marilyn Martin. I'm a physician coding educator with Vandalia Health. And I just needed, this is a clarifying question,

the presenter who presented on telehealth services spoke about adding some service billable services for training, can she repeat that portion of her presentation please?

**Emily Yoder:** Yes. Hi, this is Emily. I don't have the specific HCPS (Healthcare Common Procedure Coding System) codes, but it's caregiver training services...are the services that are available on the Medicare telehealth list.

**Marilyn Martin:** Perfect. Thank you so much.

**Emily Yoder:** No problem.

**Karen Mohr:** OK, Meagan, you may unmute and ask your question. Meagan Moyer.

**Meagan Moyer:** Hello, everyone. Thank you so much for taking my question. My question relates to CMS finalizing the permanent expansion of audio-only telehealth services. I believe I heard Emily use the word "all" in her presentation, and so thus the use of the word "all" implies that any code on the telehealth service list would be eligible for audio only, given the documentation requirements and modifier are met. So, can you please clarify, what charges would a provider drop for a telephone visit starting January 1, 2025?

**Lindsey Baldwin:** So I, so I'm not, so basically the policy is that any service on the Medicare telehealth list that can also be provided to a beneficiary in their home, which recognizes the fact that absent any legislative extensions, the home is only an eligible originating site for behavioral health services among a couple of other very specific service sets like for diagnosis and treatment of an acute stroke. But largely the big bucket is behavioral health services. Those are only available to be provided to benes in their home unless Congress acts beginning January 1, 2025. So, within that, and so right now, that is the policy. However, the way that it is sort of, we did the audio-only extension is that, were Congress to either extend the originating site waivers or if they were to, similar to how they kind of carved out behavioral health and said that it could be in the home, that we would then, those services, whatever they might be, would also be available via audio only as well without CMS needing to undertake additional rulemaking. So that's sort of the policy. And I guess I'm not quite following the question about charges.

**Meagan Moyer:** Charges meaning codes, excuse me. What billing codes, then, would a provider drop for a telephone visit starting January 1, 2025, given that the audio-only documentation requirements and the 93 modifier are met?

**Lindsey Baldwin:** Yeah, so it would be any code that is currently on the telehealth list that best describes the service furnished. We're not more specific than that in terms of providing a list of codes that can be provided via audio only. It just is dependent upon both what the requirements are around the originating site, whether the beneficiary's home is or is not extended as an originating site for all telehealth. But then also just you need to meet the requirements for the given code. That is kind of as specific as we've gotten.

**Meagan Moyer:** OK. Is the 93 modifier then still need to be added?

**Lindsey Baldwin:** I think we actually are asking for place of service, 11, which is, so no, you know what, can you send this to me in writing? I don't want to, I think I know the answer, but I don't want to say something misleading. So, if you could send that in writing, that'd be super helpful. Thank you.

**Meagan Moyer:** Sure. Thank you so much.

**Karen Mohr:** Lisa Zavala, you may unmute and ask your question.

**Lisa Zavala:** Hello. Thank you for taking my question. I have a question and a follow-up question. My first one is in the last fiscal year, final rule for '24, the waiver was still in place to allow to defer the face-to-face visit requirement prior to initiating behavioral health services through telehealth. But I noticed that it was omitted in this fiscal year '25, meaning it wasn't even in the final rule. So, does that mean at this point, beginning fiscal year '25, or calendar year '25, apologies, that the face-to-face within six months prior is required to initiate behavioral health telehealth services?

**Lindsey Baldwin:** Yes, that is correct. See, that requirement is actually, was part of the Consolidated Appropriations Act (CAA) of 2021 that made behavioral health services available via telehealth permanently in a wider range of circumstances. So, absent, again, what has happened year over year with these legislative extensions of the waivers, they have went ahead and waived that requirement as well. And so, what that means is if absent any congressional legislation—it sounds like a broken record—then yes, that would be the requirement for patients who are newly being treated for their behavioral health conditions via telehealth. I believe when we implemented the CAA in 2021 and through 2022 rulemaking, I believe we said in that rule that if the patient was already being seen via telehealth, they would not need to have, they count sort of as being—

**Lisa Zavala:** Grandfathered in.

**Lindsey Baldwin:** Sorry, what?

**Lisa Zavala:** Grandfathered in.

**Lindsey Baldwin:** Yeah, exactly. Exactly. So that is the case here as well.

**Lisa Zavala:** OK, perfect. Thank you. My follow-up question is very similar. There was...the definition of a telehealth provider included speech therapists, occupational therapists, and physical therapists. Once again, I saw that absent in this fiscal final rule, calendar year, final rule, is that the same thing, that they will no longer be able to provide telehealth services come January 1, 2025?

**Lindsey Baldwin:** That is correct, yes.

**Lisa Zavala:** OK.

**Lindsey Baldwin:** Another place where the statute would need to be amended in order to extend that waiver.

**Lisa Zavala:** OK, great. Thank you so much. I appreciate you.

**Lindsey Baldwin:** Thank you for your questions.

**Karen Mohr:** Hey, we have time for one more question. Carol Yarbrough, you may unmute and ask your question.

**Carol Yarbrough:** Thank you so much. And this is a quick question, a follow-up to the audio only. So, I know Emily, you need to go back and look at place of service and modifier for those codes. My question was going to be just a little bit more specific, even though it's any code, does that apply to any code that's already approved as being approved for audio only, or would that include 99202 through 99215, which are the outpatient evaluation and management codes?

**Lindsey Baldwin:** Hi Carol. It's always good to hear your voice.

**Carol Yarbrough:** Hi. Thank you.

**Lindsey Baldwin:** So that's right. So, we have not gone through and made a code-by-code determination in terms of what is available via audio only because for example, specifically with that code set that you highlighted, it is not condition specific. And so even if we're just talking about a behavioral health service provided via telehealth to a beneficiary in their home via communication modality, audio, video, audio only, that could be reported potentially depending on the specific circumstances with an outpatient, with an office outpatient E&M visit. And so, we did not to get into any more detail about how we would go about sort of identifying that. And so, no. So, I'd say yes, there are circumstances certainly where an office outpatient E&M could be provided.

**Carol Yarbrough:** Great. Because sometimes psychiatrists do an E&M plus the behavioral health. So that's absolutely awesome. Thank you so much. I appreciate it.

**Lindsey Baldwin:** Thank you, Carol.

**Jill Darling:** Everyone, thank you so much for joining us. We are at time. I did send the Medicare Physician Fee Schedule email to everyone in case, if you were in the question queue and you did not get a chance to ask your question, please email it in. And to anyone else that is interested, again, we thank you for joining us today and this concludes today's call. Have a great day, everyone.