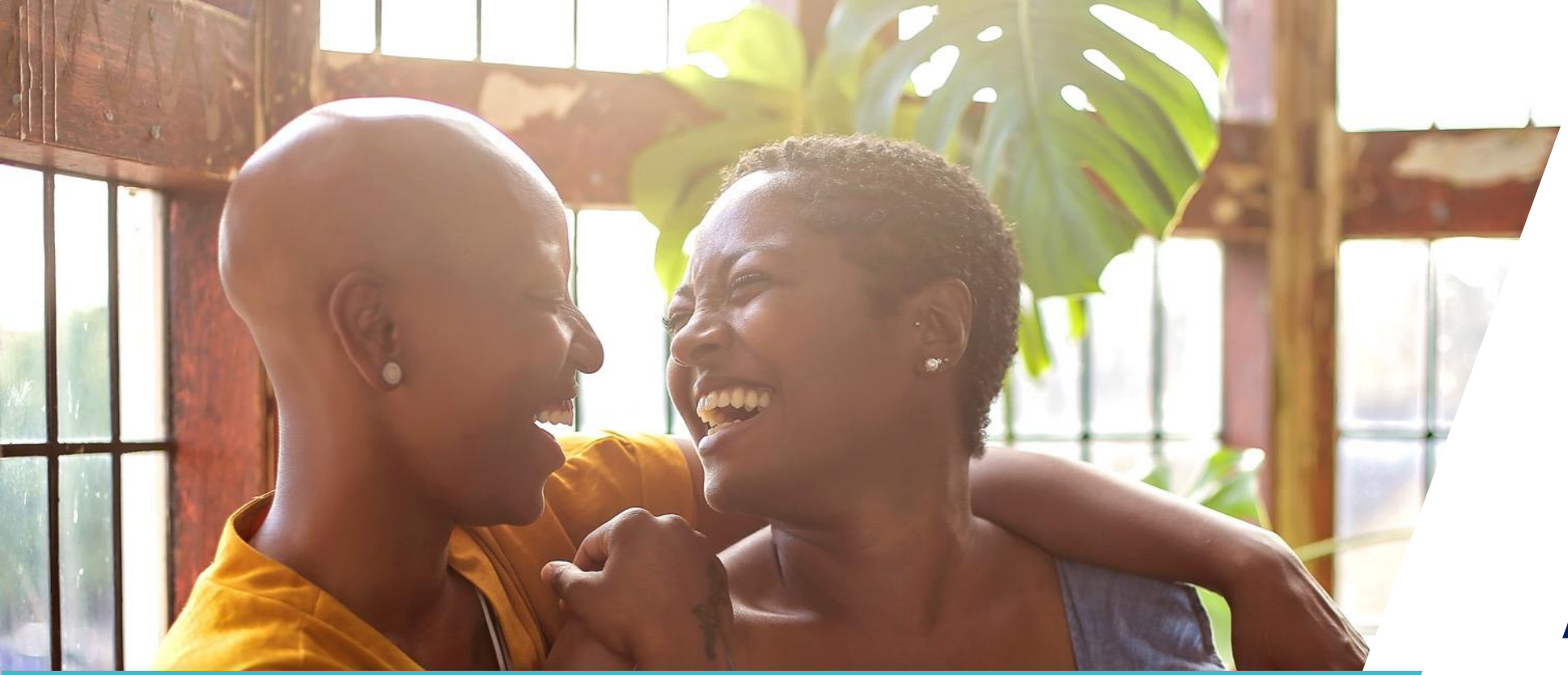


American Cancer Society®

NATIONAL NAVIGATION ROUNDTABLE

April 4, 2024

Empowering Patient Care: Navigating the CMS Cost Share Landscape with PIN Services in the Physician Fee Schedule 2024

The American Cancer Society National Navigation Roundtable (ACS NNRT) was established in 2017. The ACS NNRT is a national coalition of 80 member organizations to advance navigation efforts that eliminate barriers to quality care, reduce disparities, and foster ongoing health equity across the cancer continuum. The American Cancer Society provides organizational leadership and expert staff support to the ACS NNRT.

Jennifer Greenwald, MPH

ACS Senior Vice President, Patient Support Strategy & Operations, Tri-Chair of ACS NNRT

American Cancer Society®

NATIONAL NAVIGATION ROUNDTABLE

Zoom Best Practices

This meeting will be recorded.

You will be muted with your video turned off when you join the call.

This call takes place on the Zoom platform. To review Zoom's privacy policy, please visit zoom.us/privacy

Questions? Type them in the Question-and-Answer box at the bottom of your screen.

thank you!

This project is funded partially by Sanofi, Pfizer, Novocure, and Daiichi-Sankyo

Archived Webinar

Pursuing Patient Navigation Policy Landscape

December 6, 2023
2 p.m. - 3:15 p.m.

MISSION:

High quality cancer care for all through evidence-based patient navigation

VISION:

NNRT is a collaboration that advances patient navigation efforts to eliminate barriers for quality care, reduce disparities in health outcomes and foster ongoing health equity across the cancer continuum.

Five-Year AIM (2021-2026)

To support the creation of a sustainable model for oncology patient navigation to achieve health equity across the continuum of cancer care.

National Navigation Roundtable (NNRT)

https://navigationroundtable.org/

Partner with ACS CAN on Federal, State & Regulatory Initiatives to inform & continue to influence fiscal sustainability models.

2024 and beyond

- Identify gaps in patient navigation research
- Analyze existing, proposed and potential policies for sustainable funding models
- Engage stakeholders and education policymakers on importance of patient navigation to end cancer as we know it, for everyone

State Policy Recommendations

- Medicaid Reimbursement for Community Health Workers
- State Plan Amendments
- State Appropriations
- Certification and Training

CMS Physician Fee Schedule
AMA & new CPT Codes

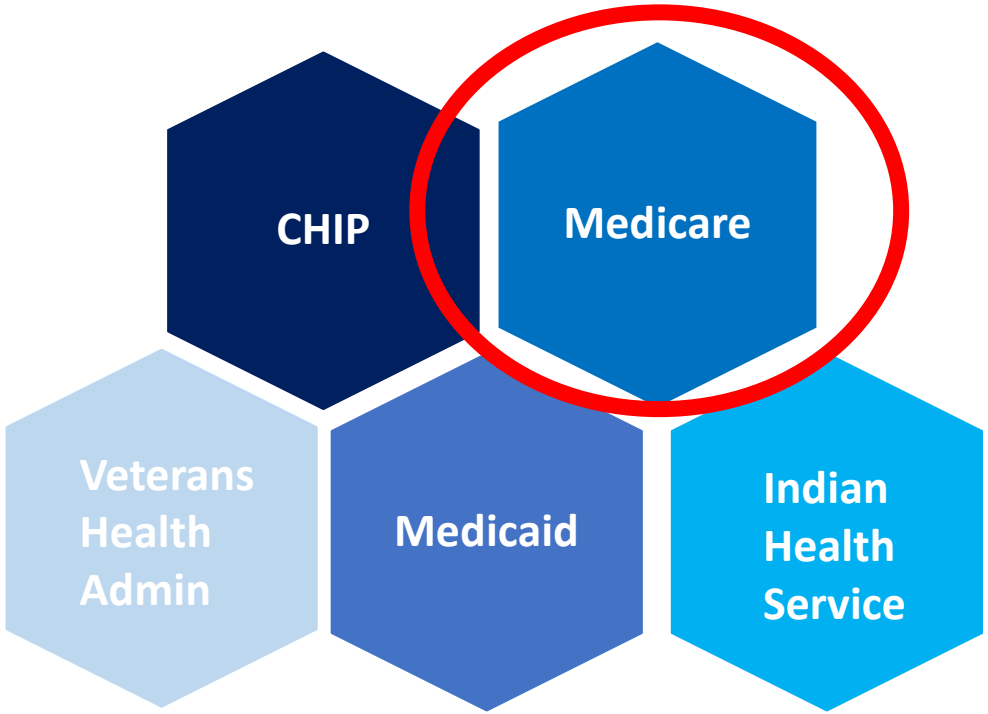
Katie Garfield, JD
Director of Whole Person Care
Clinical Instructor, Health Law and Policy Clinic
Center For Health Law Policy Innovation Of
Harvard Law School

Rachel Landauer
Clinical Instructor Health Law and Policy Clinic
Center for Health Law and Policy Innovation of
Harvard Law School

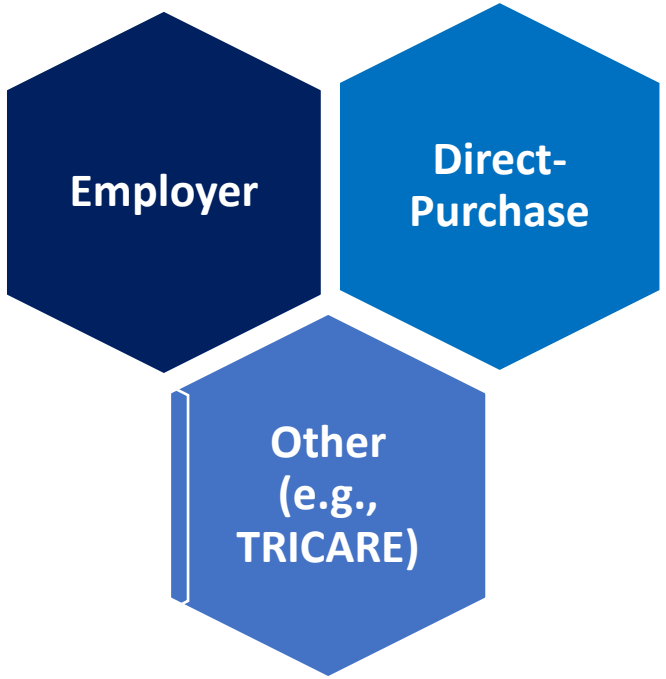
Presenters

U.S. Health Insurance Landscape

Public Health Insurance



Private Health Insurance



Medicare: An Overview

- **Medicare:**
  - Serves individuals aged 65+ or who are living with disabilities or End Stage Renal Disease (ESRD)

- **Broken into 4 Parts:**
  - Part A: Hospital Insurance
  - Part B: Medical Insurance
  - Part C: Medicare Advantage (Private Health Plans)
  - Part D: Prescription Drug Coverage

Background

- **Medicare Physician Fee Schedule (PFS)**
  - **Medicare** reimburses physicians (and other enrolled health care providers) for services provided under Medicare Part B based on the Physician Fee Schedule
  - Lists more than 10,000 unique covered service codes and their payment rates
  - Payment policies in the PFS are updated **annually** via the rulemaking process (i.e., the process used to create new regulations)

Medicare Physician Fee Schedule

Background

- **Calendar Year 2024 PFS Rule**
  - Introduced new payment policies (i.e., billing codes) relevant to **HRSN supports**
  - **Proposed Rule**: Released July 2023 for Comment
  - **Final Rule**: Released November 2023
  - **Implementation**: January 1, 2024

Key Takeaway:

*Beginning in 2024, **Medicare providers** can use these new billing codes to seek payment for community health worker and patient navigation services provided to **Medicare enrollees***

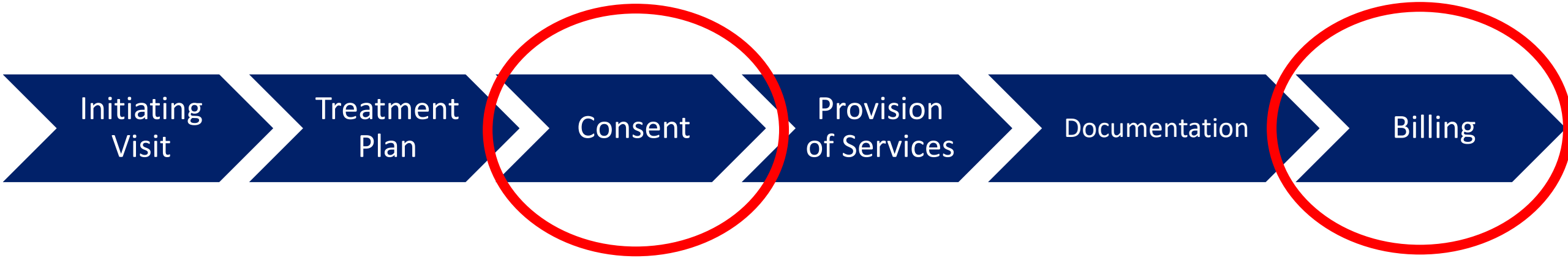
Medicare Physician Fee Schedule

Rule Summary

	Purpose	HCPCS Codes (i.e., billing codes)
Principal Illness Navigation (PIN) Services	Assist Medicare enrollees **with high-risk conditions** identify and connect with clinical and support services	**G0023** – PIN services 60 minutes/month **G0024** – PIN services, additional 30 minutes **G0140** – PIN- Peer Support, 60 minutes/month **G0146** – PIN- Peer Support, additional 30 minutes **G0511 –** Payment of PIN services in FQHCs/RHCs
Community Health Integration (CHI) Services	Address **unmet health-related social needs (HRSN)** that affect diagnosis and treatment of a Medicare enrollee's medical conditions	**G0019 –** CHI services 60 minutes/month **G0022** – CHI services, additional 30 minutes **G0511 –** Payment of CHI services in FQHCs/RHCs
Social Determinants of Health (SDOH) Risk Assessment	**Assessment** of Medicare enrollee's SDOH/social risk factors that influence diagnosis or treatment of medical conditions	**G0136 –** SDOH risk assessment 5-15 minutes, not more than every 6 months

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0 .

Process of Providing PIN Services



Medicare Part B Out-of-Pocket Costs

- Deductible
  - $240 in 2024

- Coinsurance
  - Medicare usually pays 80% of the fee schedule rate for Part B services; beneficiary is responsible for the other 20%


PIN


CHI


SDOH Risk Assessment

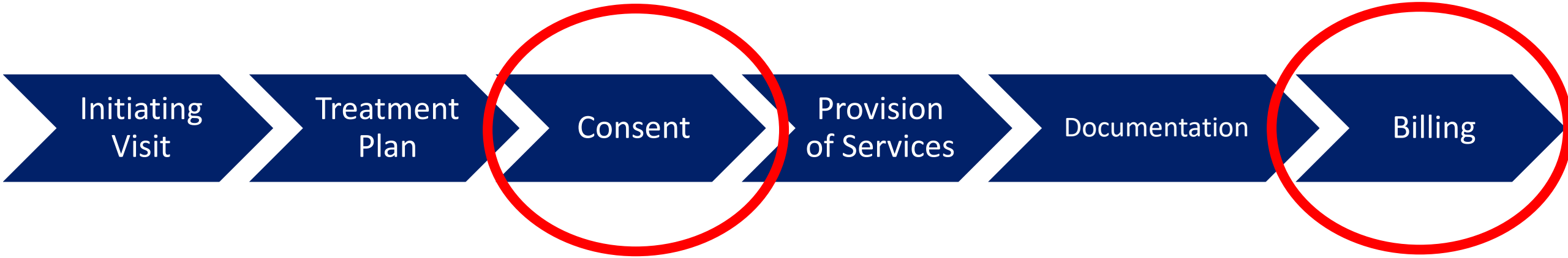
  - Coinsurance unless part of Annual Wellness Visit

Coinsurance Amounts – Estimated for 2024

Code	Maximum Fee Schedule Amount	Estimated Coinsurance Amount
G0136 (SDOH Risk Assessment)	$18.66	$3.73
G0019 (CHI Services, 60 min.)	$79.24	$15.85
G0022 (CHI Services, add 30 min.)	$49.44	$9.89
G0023 (PIN, 60 min.)	$79.24	$15.85
G0024 (PIN, add 30 min.)	$49.44	$9.89
99492 (PIN - Peer Support, 60 min.)	$79.24	$15.85
99493 (PIN - Peer Support, add 30 min.)	$49.44	$9.89
G0511 (Federally Qualified Health Centers & Rural Health Clinics)	$70.71	$14.14

Impacts on Workflow

- Who talks to the patient about coinsurance?
- Who pays? Is it necessarily the patient?
- How is coinsurance collected?
- What if the patient can't pay? Can I still provide services if the patient can't pay?



Talking to Patients

- **CHI/PIN**: Beneficiaries should be alerted to coinsurance obligations as part of the **consent process** for CHI and PIN.
  - Consent may be obtained by the billing provider or by their auxiliary personnel
    - E.g., a person who contracts with the provider to deliver navigation services

- **SDOH Risk Assessment**: Providers are encouraged to notify beneficiaries of coinsurance obligations as applicable.

Checking for Supplemental Insurance

- Many beneficiaries have other insurance that will cover the beneficiary coinsurance amount.
  - **Medigap**: Private supplemental insurance policy
  - **Medicaid**: Medicaid covers coinsurance amounts for Qualified Medicare Beneficiaries (QMB) and may cover coinsurance amounts for non-Qualified Medicare Beneficiaries
    - Majority of dually-eligible beneficiaries are QMB

- **Not all beneficiaries have supplemental insurance.**

Collecting From Supplemental Insurance

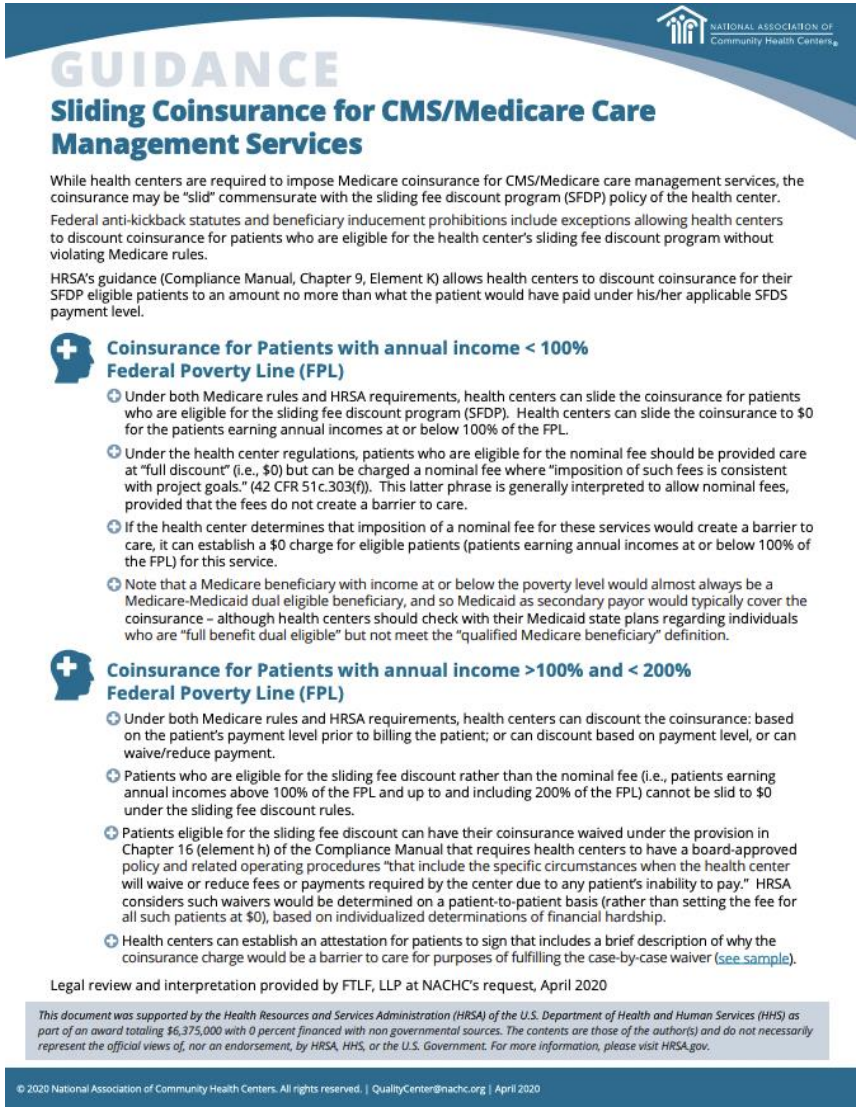
- **Medigap**
  - The Medicare Part B provider is also responsible for billing a beneficiary's Medigap policy
  - Unless the policy has a deductible that has not yet been met, plan must accept a notice of Medicare payment as a claim
- **Medicaid**
  - Medicare automatically "crosses over" claims to states
  - Provider must be enrolled as a Medicaid provider but does not need to submit a separate claim

Patient Payment Out of Pocket

- Providers can consult clinic policy / legal counsel about:
  - **Waiving financial obligations**
    - Routine vs. individually-determined waiver for beneficiary with financial hardship
  - **Forgiving financial obligations**
    - Medical record should reflect that there were normal, reasonable attempts to collect payment before a charge is written off

Special Considerations for FQHCs

- Federally Qualified Health Centers have sliding fee discount programs for patients below certain income levels
- OK to reduce coinsurance in line with the discount program
- Cannot waive the remaining amount



NATIONAL ASSOCIATION OF Community Health Centers

GUIDANCE

Sliding Coinsurance for CMS/Medicare Care Management Services

While health centers are required to impose Medicare coinsurance for CMS/Medicare care management services, the coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center.

Federal anti-kickback statutes and beneficiary inducement prohibitions include exceptions allowing health centers to discount coinsurance for patients who are eligible for the health center's sliding fee discount program without violating Medicare rules.

HRSA's guidance (Compliance Manual, Chapter 9, Element K) allows health centers to discount coinsurance for their SFDP eligible patients to an amount no more than what the patient would have paid under his/her applicable SFDS payment level.

Coinsurance for Patients with annual income < 100% Federal Poverty Line (FPL)

- Under both Medicare rules and HRSA requirements, health centers can slide the coinsurance for patients who are eligible for the sliding fee discount program (SFDP). Health centers can slide the coinsurance to $0 for the patients earning annual incomes at or below 100% of the FPL.
- Under the health center regulations, patients who are eligible for the nominal fee should be provided care at "full discount" (i.e., $0) but can be charged a nominal fee where "imposition of such fees is consistent with project goals." (42 CFR 51c.303(f)). This latter phrase is generally interpreted to allow nominal fees, provided that the fees do not create a barrier to care.
- If the health center determines that imposition of a nominal fee for these services would create a barrier to care, it can establish a $0 charge for eligible patients (patients earning annual incomes at or below 100% of the FPL) for this service.
- Note that a Medicare beneficiary with income at or below the poverty level would almost always be a Medicare-Medicaid dual eligible beneficiary, and so Medicaid as secondary payor would typically cover the coinsurance – although health centers should check with their Medicaid state plans regarding individuals who are "full benefit dual eligible" but not meet the "qualified Medicare beneficiary" definition.

Coinsurance for Patients with annual income >100% and < 200% Federal Poverty Line (FPL)

- Under both Medicare rules and HRSA requirements, health centers can discount the coinsurance: based on the patient's payment level prior to billing the patient; or can discount based on payment level, or can waive/reduce payment.
- Patients who are eligible for the sliding fee discount rather than the nominal fee (i.e., patients earning annual incomes above 100% of the FPL and up to and including 200% of the FPL) cannot be slid to $0 under the sliding fee discount rules.
- Patients eligible for the sliding fee discount can have their coinsurance waived under the provision in Chapter 16 (element h) of the Compliance Manual that requires health centers to have a board-approved policy and related operating procedures "that include the specific circumstances when the health center will waive or reduce fees or payments required by the center due to any patient's inability to pay." HRSA considers such waivers would be determined on a patient-to-patient basis (rather than setting the fee for all such patients at $0), based on individualized determinations of financial hardship.
- Health centers can establish an attestation for patients to sign that includes a brief description of why the coinsurance charge would be a barrier to care for purposes of fulfilling the case-by-case waiver (see sample).

Legal review and interpretation provided by FTLF, LLP at NACHC's request, April 2020

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What about Medicare Part C?

- Medicare Part C (Medicare Advantage) plans must include coverage for Part B benefits
- Copays and other out-of-pocket costs depend on the terms of the beneficiary's Medicare Part C (Medicare Advantage) plan

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Questions

Pfizer

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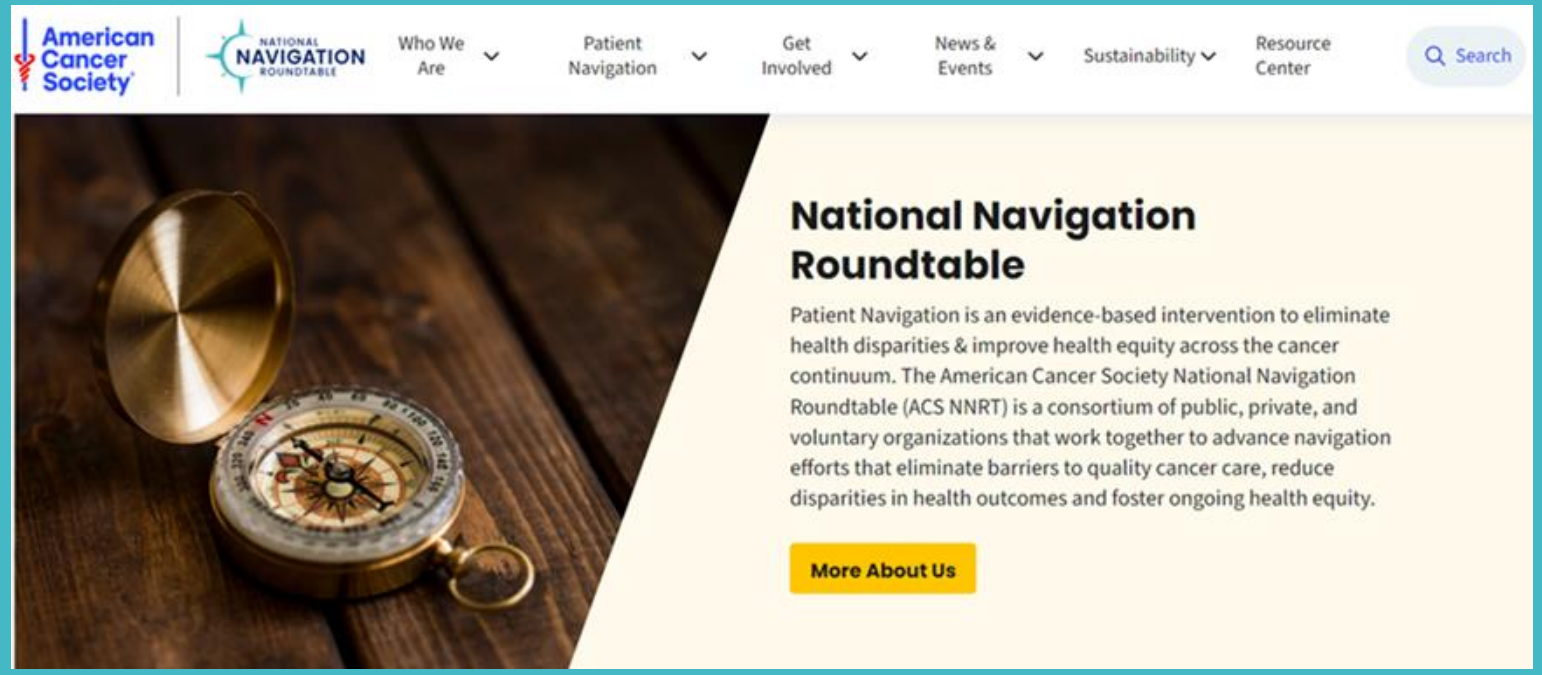

THANK YOU