



# 2025 Medicare Physician Fee Schedule Rule and RHC Strategic Impacts

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## Meet the Presenter



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# Agenda

1. Overview of Changes
2. All-Inclusive Rate Reviews
3. Strategic Impact of Changes
4. Questions

# Removal of 51% Primary Care Threshold

RHC have historically been required to have at least 51% of the services rendered be related to primary care:

- Family medicine
- Pediatrics
- Internal medicine
- OB/GYN

May represent an opportunity to incorporate more specialist services into the RHC setting

- Behavioral health, orthopedics, cardiology, etc.
- Need to evaluate reimbursement for services to determine optimal service location

Effective January 1, 2025

# Removal of Provider Productivity Standards

RHC providers have historically been held to productivity standards and failure to meet those standards may have decreased reimbursement:

- Physicians – 4,200 visits per FTE
- APP Providers – 2,100 visits per FTE
- Evaluated at the practice level, not individual providers

May represent an opportunity to incorporate more specialist services into the RHC setting

- Behavioral health, orthopedics, cardiology, etc.
- Need to evaluate reimbursement for services to determine optimal service location
- Potential changes to staffing models

Effective for cost reporting periods beginning on or after January 1, 2025

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# Removal of Provider Productivity Standards

- Existing RHCs may change location and retain existing AIR
  - New location must meet all location requirements
  - RHC status may be lost if new location does not qualify
  - Conditions of participation must be met and survey may be required
- Suite within a building with same “parent” address may be added onto the existing enrollment



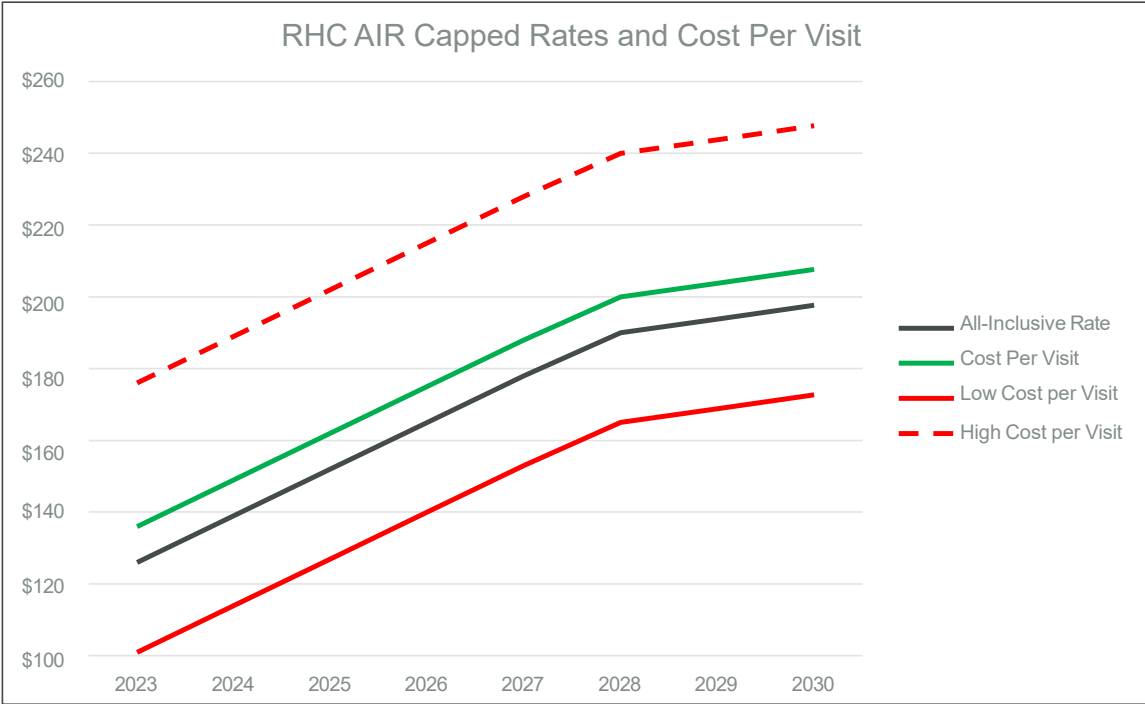
## 2021 CAA Introduced AIR Caps

- Applicable to all newly certified RHCs
- Existing provider-based RHCs where bed availability was less than 50 beds not subject to caps
  - Rate based on finalized 2020 cost report and increases by MEI
  - If bed count exceeds 50 beds grandfathered rate is forfeited
- Periodic reviews needed to maximize benefits

### AIR Caps Per Year

| Year            | AIR Cap       |
|-----------------|---------------|
| 2023            | \$126         |
| 2024            | \$139         |
| 2025            | \$152         |
| 2026            | \$165         |
| 2027            | \$178         |
| 2028            | \$190         |
| 2029 and Beyond | MEI (1% - 3%) |

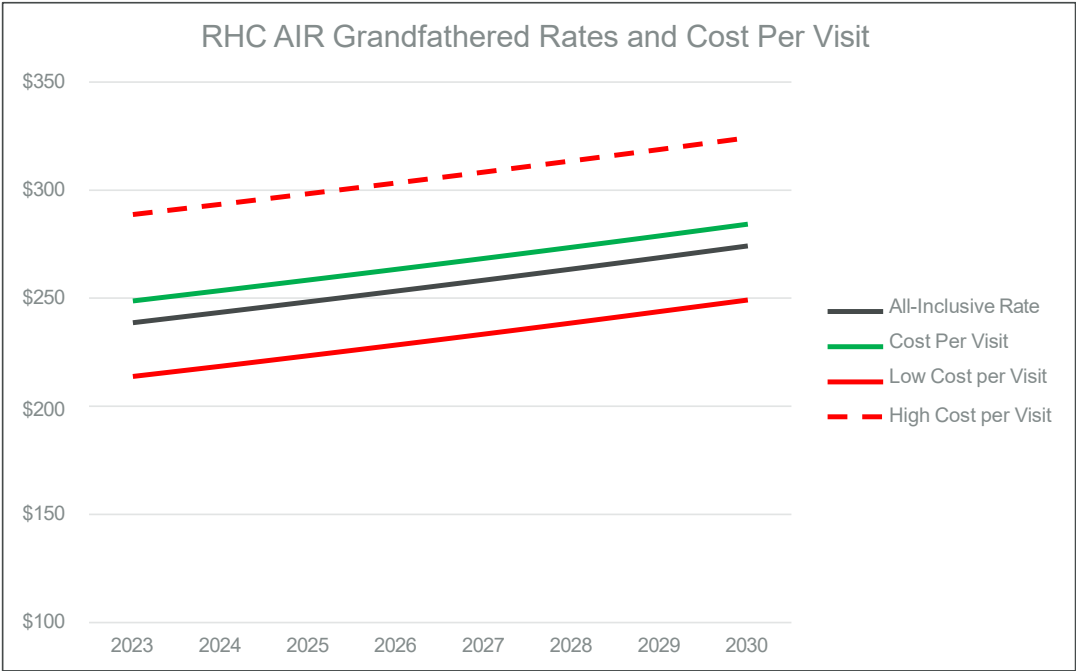
# RHC AIR Strategy – Capped Rates



|                  | 2025 AIR  | 2025 CPV    |
|------------------|-----------|-------------|
| AIR              | \$152     | \$114       |
| Visits           | 5,000     | 5,000       |
| Total Revenue    | \$760,000 | \$570,000   |
| Revenue Variance |           | (\$190,000) |



# RHC AIR Strategy – Grandfathered Rates



Assumes 2020 Rate of \$225 and MEI of 2% per Year

|                  | 2025 AIR    | 2025 CPV    |
|------------------|-------------|-------------|
| AIR              | \$249       | \$219       |
| Visits           | 5,000       | 5,000       |
| Total Revenue    | \$1,245,000 | \$1,095,000 |
| Revenue Variance |             | (\$150,000) |

# Billing for Chronic Care Management Services

RHC providers have historically been required to bill for CCM using code G0511 instead of actual CPT codes for services rendered:

- G0511 reimbursed based on an average of reimbursement amounts for CCM related CPT codes
- Lack of visibility to actual CCM services rendered

May result in increased or decreased reimbursements based on the actual CPT codes billed

Effective July 1, 2025 (or later as determined by CMS)

# Payment for Preventive Vaccine Costs

RHC providers will now be permitted to bill and be paid for Part B preventive vaccines and their administration at the time of service:

- Paid according to Part B preventive vaccine rates
- Payments reconciled annually on the cost report

May result in increased cash flow and improve the timeliness of payment for RHCs that offer preventive vaccines

Effective for dates of service on or after July 1, 2025

# Continuation of Telehealth Flexibilities

RHCs may continue to bill and be reimbursed for telehealth services using CPT code G2025, including for services that utilized audio-only communications through December 31, 2025:

- Continue to be paid according to special payment rate
- Non-mental health encounters should **not** be counted in RHC visit counts
- Mental health services provided by telehealth are eligible for all-inclusive rate payment

May result in opportunity to allow patients to complete their visits if transportation has provided a barrier to care. May still be beneficial to have patients seen in the clinic.

Effective through December 31, 2025

# Strategic Impacts of Changes

- Ability to allow specialists to practice more often in an RHC
  - Additional RHC cost capture
  - Increased services for community
  - Greater opportunity to remain above AIR caps
  - Be mindful of which services are performed in the RHC setting
- Ability to convert specialist and/or multispecialty clinics to RHCs
  - Potential for increased reimbursement
  - Must provide some primary care in clinic
- Potential system upgrades needed
  - Individual CCM CPT code billing and potential financial impact
  - Preventive vaccine billing and cost report settlement impact

# Strategic Impacts of Changes

- Potential system upgrades needed
  - Individual CCM CPT code billing and potential financial impact
  - Preventive vaccine billing
    - Cash flow and cost report settlement impact
- Utilization of telehealth in RHC setting
  - Need for increased utilization?
  - For which services?
- Cost reporting
  - Continual review of estimated AIR calculations (quarterly, semiannually, etc.)
  - Evaluation of existing non-reimbursable clinics and impact if converted to RHC

Questions?



Thank You!

