Small Entity Compliance Guide

Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments; Final Rule (CMS-1807-F & CMS-4201-F5)

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The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA, Pub. L. 104-121, as amended by Pub. L. 110-28, May 25, 2007) contains requirements for issuance of "small entity compliance guides." Guides are to explain what actions affected entities must take to comply with agency rules. Such guides must be prepared when agencies issue final rules for which agencies were required to prepare a Final Regulatory Flexibility Analysis under the Regulatory Flexibility Act (RFA).

The complete text of this final rule can be found on the CMS website at https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f.

Summary

This final rule addresses: changes to the physician fee schedule (PFS); other changes to Medicare Part B payment policies to ensure that payment systems are updated to reflect changes in medical practice, relative value of services, and changes in the statute; codification of establishment of new policies for, the Medicare Prescription Drug Inflation Rebate Program under the Inflation Reduction Act of 2022; updates to the Medicare Diabetes Prevention Program expanded model; payment for dental services inextricably linked to specific covered medical services; updates to drugs and biological products paid under Part B including immunosuppressive drugs and clotting factors; Medicare Shared Savings Program requirements; updates to the Quality Payment Program; Medicare coverage of opioid use disorder services furnished by opioid treatment programs; updates to policies for Rural Health Clinics and Federally Qualified Health Centers; electronic prescribing for controlled substances for a covered Part D drug under a prescription drug plan or a Medicare Advantage Prescription Drug (MA-PD) plan under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act); update to the Ambulance Fee Schedule regulations; codification of the Inflation Reduction Act and Consolidated Appropriations Act, 2023 provisions; updates to Clinical Laboratory Fee Schedule regulations; updates to the diabetes payment structure and PHE flexibilities; updates to coverage of colorectal cancer screening and expansion of Hepatitis B vaccine coverage and payment; establishing payment for drugs covered as additional preventive services; Medicare Parts A and B Overpayment Provisions of the Affordable Care Act and Medicare Parts C and D Overpayment Provisions of the Affordable Care Act.

Background

Since 1992, Medicare has paid for the services of physicians and other billing professionals under the PFS. Physicians' services paid under the PFS are furnished in a variety of settings, including physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-

acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Payment under the PFS is also made to several types of suppliers for technical services, often in settings for which no institutional payment is made. For most services furnished in a physician's office, Medicare makes payment to physicians and other professionals at a single rate based on the full range of resources involved in furnishing the service. In contrast, PFS rates paid to physicians and other billing practitioners in facility settings, such as a hospital outpatient department (HOPD) or an ambulatory surgical center (ASC), reflect only the portion of the resources typically incurred by the practitioner in the course of furnishing the service. For many diagnostic tests and a limited number of other services under the PFS, separate payment may be made for the professional and technical components of services. The technical component is frequently billed by suppliers, like independent diagnostic testing facilities and radiation treatment centers, while the professional component is billed by the physician or practitioner.

Under the PFS, the unit of payment is generally considered to be a single service, such as an office visit or diagnostic procedure, though there are many significant exceptions. The majority of the more than 7,000 codes describing services are maintained under the Current Procedural Terminology definitions, copyrighted by the American Medical Association (AMA).

Provisions of the Final Rule

Medicare Diabetes Prevention Program (MDPP): The Medicare Diabetes Prevention Program (MDPP) is a non-pharmacological behavioral intervention consisting of up to 22 sessions using a CDC-approved National Diabetes Prevention Program (National DPP) curriculum. CDC administers a national quality assurance program recognizing eligible organizations that furnish the National DPP through its evidence-based Diabetes Prevention Recognition Program (DPRP) Standards, which are updated every three years. The 2024 CDC DPRP Standards were effective June 1, 2024. CMMI is finalizing conforming changes to MDPP through the final rule that are needed to align MDPP with the 2024 CDC DPRP Standards. We are also finalizing administrative changes to remove the MDPP bridge payment, provide a more effective option for self-reporting weight in an MDPP distance learning session, facilitate processing of MDPP make-up sessions held on the same day as a regularly scheduled session, and align current rule language with previous rulemaking.

Quality Payment Program (QPP): The Quality Payment Program (QPP) was authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which ended the Sustainable Growth Rate (SGR) formula and established QPP as a forward-looking, coordinated framework for clinicians to participate either as individuals, groups, or Advanced Alternative Payment Model (APM) entities. The program establishes a model of funding that rewards clinicians who provide high-quality patient-centered care. QPP aims to improve the quality and safety of care for all individuals and to reduce the administrative burden on clinicians, allowing more time to focus on person-centered care and improving health outcomes. Eligible clinicians include physicians, physician assistants, nurse practitioners, and a broad array of other types including clinical psychologists, and physical and occupational therapists, among others. QPP is composed of two participation tracks:

1. The Merit-based Incentive Payment System (MIPS) is a budget neutral pay-for-performance program. Under MIPS, we evaluate performance across multiple categories that lead to improved quality and value in our healthcare system. Clinicians receive positive, neutral, or negative adjustments to their fee-for-service (FFS) payments based on their performance in four categories: Quality, Cost, Promoting Interoperability, and Improvement Activities. Within MIPS, we are developing MIPS Value Pathways (MVPs), which offer more meaningful groupings of measures and activities, to provide a more connected assessment of the quality of care across the performance categories.

2. Advanced Alternative Payment Models (APMs), which are types of APMs that include specific features and allow participating eligible clinicians to seek Qualifying APM Participant (QP) status by achieving threshold levels of payment amounts or patient counts through the Advanced APM. QPs are exempt from MIPS.

PFS Conversion Factor (CF): We implement both the PFS update and budget neutrality to account for changes in values CMS assigns for individual services through changes to both the PFS conversion factor and relative value units (RVUs). We estimate the CY 2025 PFS CF to be 32.3465 which reflects a 0.02% positive budget neutrality adjustment required under section 1848(c)(2)(B)(ii)(II) of the Social Security Act (the Act), the 0.00 percent update adjustment factor specified under section 1848(d)(19) of the Act, and the removal of the temporary 2.93 percent payment increase for services furnished from March 9 through the end of CY 2024, as provided in the Consolidated Appropriations Act (CAA), 2024.

TABLE 1: Physician Fee Schedule (PFS) Payment Rate Updates

CY 2024 Conversion Factor		33.2875
Conversion Factor without the CAA, 2024 (2.93 Percent Increase for CY 2024)		32.3400
CY 2025 Statutory Update Factor	0.00 percent (1.0000)	
CY 2025 RVU Budget Neutrality Adjustment	0.02 percent (1.0002)	
CY 2025 Conversion Factor		**32.3465**

TABLE 2: Historical Updates and PFS Conversion Factors (CF)[1]

	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
CF in Previous CY	36.0391	36.0896	34.8931	34.6062	33.8872	33.2875
CF in Previous CY without CAA Provision (if applicable)	-	-	33.6319	33.5983	33.0607	32.3400
Update Factor	1.0000	1.0375	1.0300	1.0250	1.0293[5]	N/A
Relative Value Units (RVU) Budget Neutrality Adjustment	1.0014	0.9319	0.9990	0.9840	0.9782	TBD
New Conversion Factor	36.0896	34.8931[2]	34.6062[3]	33.8872[4]	33.2875[5]	32.3465

[1]The Social Security Act (the Act) requires that increases or decreases in RVUs may not cause the annual expenditures to differ by more than $20 million from what expenditures would have been in the absence of these changes. We maintain this budget-neutral requirement through a combination of the adjustment to the conversion factor and RVUs changes.
[2] The CAA, 2021 provided a 3.75 percent increase in PFS payments for CY 2021.
[3] The CAA, 2022 provided a 3.00 percent increase in PFS payments for CY 2022.
[4] The CAA, 2022 provided a 2.50 percent increase in PFS payments for CY 2023.
[5] The CAA, 2022 provided a 1.25 percent increase in PFS payments for January 1-March 8, 2024, which was replaced by a 2.93 percent increase for PFS payments for March 9-December 31, 2024, by the CAA, 2024, which is due to expire for CY 2025.

Notable Timing Factors and Administration Priorities:
The statute requires the final rule to publish by November 1 to be effective January 1, 2025.

Noteworthy Elements about Equity:

We expect that the provisions for MDPP will make the program more equitable. These conforming and administrative changes are needed to fully implement the changes put into effect by the CY 2024 final rule that were designed to increase health equity by increasing access to MDPP in underserved communities where there are disparities in diabetes.

We expect that the provisions for behavioral health, telehealth, advanced primary care management, and evaluation and management services will positively impact health equity by emphasizing holistic and supportive patient centered care. We are further refining some of our PFS coding and

payment provisions that are designed to better address Health-Related Social Needs by accounting for resources involved in patient-centered care involving a multidisciplinary team of clinical and auxiliary personnel, including community health workers, care navigators, caregivers, and peer support specialists, potentially increasing access to care for the Medicare population (particularly in Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), underserved, and low-income populations, where there is a disparity in access to quality care). The Shared Savings Program provisions will help expand accountable care to underserved communities and populations through the health equity benchmark adjustment and prepaid shared savings.

We continue to explore opportunities to advance health equity in accordance with the CMS Framework for Health Equity, across all CMS programs and policies, including the MVPs framework and MIPS quality reporting. We have evaluated our provisions to ensure that they will not place any additional burden on underserved communities, including people of color, disproportionately affected communities, or safety net/essential community providers. We continue to offer policies and bonuses available for clinicians who treat complex patients and are a part of a small practice. Currently, the MIPS Quality Measure Inventory includes two health equity quality measures: Q487: Screening for Social Drivers of Health; and Q498: Connection to Community Service Provider. Additionally, starting with the CY 2024 performance period, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Measure requires the administration of the Spanish translation of the Survey. Furthermore, all MVPs include improvement activities that include health equity components.

The provisions to update and expand CRC screening and hepatitis B vaccination coverage align with the administration's strategic pillar to advance health equity by addressing the health disparities in colorectal cancer and hepatitis B outcomes.

Novel Elements to Consider:

Advanced Primary Care Management (APCM): For CY 2025, we finalized our proposal to establish new coding and payment for Advanced Primary Care Management (APCM) services, caregiver training for direct care services and supports, and for an annual Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment service. In the proposed rule, we requested information on the newly implemented Community Health Integration/Principal Illness Navigation (CHI/PIN) Services and Social Determinants of Health (SDOH) Risk Assessment to engage interested parties on additional policy refinements for CMS to consider in future rulemaking. We also sought comment from interested parties through an Advanced Primary Care Hybrid Payment RFI on whether and how we should consider additional payment policies that recognize the delivery of advanced primary care. We summarized the comments received in response to these RFIs in the final rule and may consider these comments for future rulemaking.

Medicare Diabetes Prevention Program (MDPP): For CY 2025, we proposed conforming and administrative changes that are needed to: (1) align MDPP with the proposed 2024 CDC DPRP Standards; (2) remove the MDPP bridge payment; (3) provide a more effective option for a beneficiary to self-report their weight in an MDPP distance learning session; (4) allow MACs to process claims for MDPP make-up sessions held on the same day as a regularly scheduled session; and (5) align current rule language with previous rulemaking. These provisions aim at achieving the CMS strategic goals to advance equity and expand access and support CMS in preventing fraud, waste, and abuse in its programs.

Telehealth: For telehealth, we discussed several provisions in this year's rule including the provision to add several services to the Medicare Telehealth Services List on a provisional basis, including caregiver training services and to remove the frequency limitations for subsequent

inpatient visits, subsequent nursing facility visits, and critical care consultations for CY 2025.

Dental: For Parts A and B payment for dental services inextricably linked to other covered medical services, we are finalizing, for example, to amend our regulations at § 411.15(i)(3) and add to the list of clinical scenarios under which fee-for-service payment may be made for dental services inextricably linked to Medicare covered services to now include dialysis services in the treatment of end-stage renal disease.

Strategies for Improving Global Surgery Payment Accuracy: The rule also finalizes a provision to broaden the downward payment adjustment for 90-day global surgical packages in any case when a practitioner (or group practice) does not expect to furnish the post-operative care portion of the complete payment package, even when there is no formal, documented transfer of care.

Advancing Access to Behavioral Health Services: We are also finalizing provisions to advance access to behavioral health services. Finally, we are also finalizing updates to Evaluation & Management (E/M) services, the Ambulance Fee Schedule, and the Shared Savings Program. Routine technical updates include a provision to establish work relative value units (RVUs) (based on the recommendations from the AMA's Relative Value Scale Update Committee) with refinements to approximately 30 percent of the 130 plus codes reviewed this year.

Updates to Coverage of Colorectal Cancer Screening: We are finalizing an update and expansion of coverage of colorectal cancer (CRC) screening. We are removing coverage of barium enema as a method of screening because this service is rarely used in Medicare and is no longer recommended as an evidence-based screening method. We are also expanding coverage for CRC screening to include computed tomography colonography (CTC). Finally, we are adding Medicare covered blood-based biomarker CRC screening tests as part of the continuum of screening. Like stool-based CRC screening tests, which are already in the definition of a "complete CRC Screening," a blood-based biomarker test with a positive result will lead to a follow-on screening colonoscopy (with no beneficiary cost-sharing). We are also revising the regulation text to clarify that CRC screening frequency limitations do not apply to the follow-on screening colonoscopy in the context of "complete CRC screening." These actions will promote access and remove barriers for much needed cancer prevention and early detection within rural communities and communities of color that are especially impacted by the incidence of CRC.

Expansion of Hepatitis B Vaccine Coverage and Payment: For CY 2025, we are addressing two issues related to coverage and payment of the hepatitis B vaccine and its administration under Part B. Hepatitis B is a vaccine-preventable, communicable disease of the liver. In this final rule, we are expanding coverage of hepatitis B vaccinations to include individuals who have not previously received a completed hepatitis B vaccination series or whose vaccination history is unknown. This policy expansion will help protect Medicare beneficiaries from acquiring hepatitis B infection and contribute to eliminating viral hepatitis as a viral health threat in the United States.

In this rule, we clarify that a physician's order will no longer be required for the administration of a hepatitis B vaccine under Part B, which will facilitate roster billing by mass immunizers for hepatitis B vaccine administration. Additionally, we are finalizing a policy to set payment for hepatitis B vaccines and their administration at 100 percent of reasonable cost in RHCs and FQHCs, separate from payment under the FQHC PPS or the RHC All-Inclusive Rate (AIR) methodology, in order to streamline payment for all Part B vaccines in those settings.

Medicare Shared Savings Program: The changes to the Shared Savings Program policies are designed to promote our value-based strategy goals of growth, equity, and alignment. The major changes that were finalized include allowing Accountable Care Organizations (ACOs) with a

history of success in the program to receive "prepaid shared savings" which can be used to offer direct beneficiary services to beneficiaries. Additionally, we will further incent ACO participation and expansion to underserved communities by adopting a health equity benchmark adjustment. We are also finalizing policies to move towards the Universal Foundation of quality measures, creating better quality measure alignment for providers and driving care transformation toward digital quality measurement. We are finalizing our proposal to mitigate the impact of significant, anomalous, and highly suspect (SAHS) billing activity in CY 2024 or subsequent calendar years on annual ACO financial reconciliation, under which we would proactively address large scale, unexplained billing anomalies identified using criteria described in the final rule that meet the high bar for removal. We are also finalizing our proposal to establish a calculation methodology to account for the impact of improper payments in recalculating an ACO's financial performance results, including improper payments identified by CMS based upon a request by an ACO to reopen its payment determination. Additionally, other routine updates to the Shared Savings Program were also finalized.

Small Entities Affected

For purposes of the RFA, physicians, nonphysician practitioners (NPPs), and suppliers including independent diagnostic testing facilities (IDTFs) are considered small businesses if they generate revenues of $10 million or less, according to the Small Business Administration size schedule. We estimate that approximately 95 percent of practitioners, other providers, and suppliers are considered to be small entities, based upon the SBA standards. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS. Because many of the affected entities are small entities, the analysis and discussion provided in section VI. of the final rule (Regulatory Impact Analysis), as well as elsewhere in the final rule are intended to comply with the RFA requirements regarding significant impact on a substantial number of small entities. (See Table 110 (CY 2025 PFS Estimated Impact on Total Allowed Charges by Specialty) of the final rule, which show the payment impact on PFS services of the policies contained in this final rule. To the extent that there are year-to-year changes in the volume and mix of services provided by practitioners, the actual impact on total Medicare revenues will be different from those shown in Table 110.)

For the Quality Payment Program, we estimate that between 380,100 and 488,700 clinicians will become Qualifying APM Participants (QPs) in the 2025 Performance Period.

We estimate that approximately 686,645 clinicians will be MIPS eligible clinicians for the 2025 MIPS performance period. We estimate that approximately 15.47 percent of MIPS eligible clinicians will receive a negative payment adjustment and 77.51 percent will receive a positive adjustment in the 2025 MIPS Performance Period/ 2027 MIPS payment ($458 million redistributed) to MIPS eligible clinicians, as required by the statute to ensure budget neutrality.

Section 101(a) of the Medicare Access and CHIP Reauthorization Act of 2015 repealed the previous statutory update formula (known as the Sustainable Growth Rate) and specified the PFS update for CY 2015 and beyond. The PFS update for CY 2024 is 0.0 percent, which is due to the removal of the temporary 2.93 percent increase that applied from March 9, 2024, through December 31, 2024, as specified by the Consolidated Appropriations Act, 2024.

After applying the required budget neutrality adjustment, the conversion factor for January 1, 2025, through December 31, 2025 will be $32.35.

Please refer to section VI. of the final rule for the full regulatory impact analysis.

This rule imposes no direct federal compliance requirements with significant economic impacts on small entities. In order to assist physicians, NPPs, and suppliers including IDTFs in understanding and adapting to changes in Medicare billing and payment procedures, we have developed webpages that include additional material on the PFS at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.

FOR FURTHER INFORMATION CONTACT:

MedicarePhysicianFeeSchedule@cms.hhs.gov, for any issues not identified below. Please indicate the specific issue in the subject line of the email.

Michael Soracoe, (410) 786-6312, Morgan Kitzmiller, (410) 786-1623, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to practice expense, work RVUs, conversion factor, and PFS specialty-specific impacts.

Hannah Ahn, (814) 769-0143, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to potentially misvalued services under the PFS.

Mikayla Murphy, (667) 414-0093, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to direct supervision using two-way audio/video communication technology, telehealth, and other services involving communications technology.

Tamika Brock, (312) 886-7904, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to teaching physician billing for services involving residents in teaching settings.

Sarah Leipnik, (410) 786-3933, Mikayla Murphy, (667) 414-0093, Regina Walker-Wren, (410) 786-9160, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to payment for caregiver training services and addressing health-related social needs (community health integration, principal illness navigation, and social determinants of health risk assessment).

Erick Carrera, (410) 786-8949, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to office/outpatient evaluation and management visit inherent complexity add-on.

Sarah Irie, (410) 786-1348, Emily Parris (667) 414-0418, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to payment for advanced primary care management service.

Sarah Leipnik, (410) 786-3933, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to global surgery payment accuracy.

Pamela West, (410) 786-2302, for issues related to supervision of outpatient therapy services in private practices, certification of therapy plans of care, and KX modifier threshold.

Lindsey Baldwin, (410) 786-1694, Regina Walker-Wren, (410) 786-9160, Erick Carrera, (410) 786-8949, Mikayla Murphy, (667) 414-0093, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to advancing access to behavioral health services.

Michelle Cruse, (443) 478-6390, Erick Carrera, (410) 786-8949, Zehra Hussain, (214) 767-4463, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to dental services inextricably linked to other covered medical services.

Zehra Hussain, (214) 767-4463, or MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to payment of skin substitutes.

Laura Kennedy, (410) 786-3377, Adam Brooks, (202) 205-0671, Rachel Radzyner, (410) 786-8215, Rebecca Ray, (667) 414-0879, and Jae Ryu, (667) 414-0765 for issues related to Drugs and Biological Products Paid Under Medicare Part B.

MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to complex drug administration.

Glenn McGuirk, (410) 786-5723, or CLFS_Inquiries@cms.hhs.gov for issues related to Clinical Laboratory Fee Schedule.

Lisa Parker, (410) 786-4949, or FQHC-PPS@cms.hhs.gov, for issues related to FQHC payments.

Heidi Oumarou, (410) 786-7942, for issues related to the FQHC market basket.

Michele Franklin, (410) 786-9226, or RHC@cms.hhs.gov, for issues related to RHC payments.

Kianna Banks (410) 786-3498 and Cara Meyer (667) 290-9856, for issues related to RHCs and FQHCs and Conditions for Certification or Coverage.

Colleen Barbero (667) 290-8794, for issues related to Medicare Diabetes Prevention Program.

Ariana Pitcher, (667) 290-8840, or OTP_Medicare@cms.hhs.gov, for issues related to Medicare coverage of opioid use disorder treatment services furnished by opioid treatment programs.

Sabrina Ahmed, (410) 786-7499, or SharedSavingsProgram@cms.hhs.gov, for issues related to the Shared Savings Program Quality performance standard and quality reporting requirements.

Janae James, (410) 786-0801, or SharedSavingsProgram@cms.hhs.gov, for issues related to Shared Savings Program beneficiary assignment and benchmarking methodology.

Richard (Chase) Kendall, (410) 786-1000, or SharedSavingsProgram@cms.hhs.gov, for issues related to reopening ACO payment determinations, and mitigating the impact of significant, anomalous, and highly suspect billing activity on Shared Savings Program financial calculations.

Lucy Bertocci, (410) 786-3776, or SharedSavingsProgram@cms.hhs.gov, for issues related to Shared Savings Program prepaid shared savings, advance investment payments, beneficiary notice and eligibility requirements.

Rachel Radzyner, (410) 786-8215, for issues related to payment for preventative services, including preventive vaccine administration and drugs covered as additional preventive services.

Elisabeth Daniel, (667) 290-8793, for issues related to the Medicare Prescription Drug Inflation Rebate Program.

Genevieve Kehoe, Ambulatoryspecialtycare@cms.hhs.gov, or 1-844-711-2664 (Option 4) for issues related to the Request for Information: Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care.

Kimberly Long, (410) 786-5702, for issues related to expanding colorectal cancer screening.

Rachel Katonak, (410) 786-8564, for issues related to expanding Hepatitis B vaccine coverage.

Mei Zhang, (410) 786-7837, for issues related to requirement for electronic prescribing for controlled substances for a covered Part D drug under a prescription drug plan or an MA PD plan (section 2003 of the SUPPORT Act).

Katie Parker, (410) 786-0537, for issues related to Parts A and B overpayment provisions of the Affordable Care Act.

Alissa Stoneking, (410)786-1120, for issues related to Parts C and D overpayment provisions of the Affordable Care Act.

Amy Gruber, (410) 786-1542, for issues related to low titer O+ whole blood transfusion therapy during ground ambulance transport.

Renee O'Neill, (410) 786-8821, for inquiries related to Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program.

Trevey Davis, (667) 290-8527, for inquiries related to Alternative Payment Models (APMs).