

2025 Medicare Physician Payment Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule Summary

On July 10, 2024, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2025 Revisions to Payment Policies under the Medicare Physician Payment Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies [proposed rule](#) and associated [fact sheet](#). The proposed rule, scheduled to be published in the July 31, 2024, issue of the Federal Register, includes several proposals related to Medicare physician payment and the Quality Payment Program (QPP). If finalized, these policies will take effect on January 1, 2025, unless otherwise noted. Interested parties have until September 9, 2024, to provide comments on the proposed rule. The American Medical Association (AMA) will continue analyzing the rule and share a draft comment letter with the Federation in advance of this submission deadline. Attached to this summary are the AMA's analyses of CMS' impact assumptions for proposed G-codes, the advanced primary care management services, and the proposed 90-day global surgical transfer of care policy.

Payment Updates and Proposals

CY 2025 Medicare Conversion Factor

The CY 2025 Medicare conversion factor (CF) is proposed to decrease for the fifth straight year by approximately 2.80 percent from \$33.2875 to \$32.3562. Similarly, the anesthesia conversion factor is proposed to be reduced from \$20.7739 to \$20.3340. This cut is largely the result of the expiration of a 2.93 percent temporary update to the CF at the end of 2024 and a zero percent baseline update for 2025 under the Medicare Access and CHIP Reauthorization Act (MACRA). Unfortunately, these cuts coincide with ongoing growth in the cost to practice medicine as CMS projects the increase in the Medicare Economic Index (MEI) for 2025 will be 3.6 percent.

Physician practices cannot continue to absorb increasing costs while their payment rates dwindle. Both the [Medicare Physician Payment Advisory Commission \(MedPAC\)](#) and the [Medicare Trustees](#) have issued warnings about access to care problems for America's seniors and persons with disabilities if the gap between what Medicare pays physicians and what it costs to provide high-quality care continue to grow. This is why the AMA and our partners in organized medicine [strongly support](#) H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which would provide a permanent, annual update equal to the increase in the MEI and allow physician practices to invest in their practices and implement new strategies to provide high-value care. Visit the AMA's [Fix Medicare Now](#) site and join the fight for financial stability for physician practices to preserve access to care for Medicare beneficiaries.

Physician Work and Practice Expense Relative Value Changes

Relative Values

CMS is proposing to accept 90 percent of the AMA/Specialty Society RVS Update Committee (RUC) [recommendations](#) for new/revised Current Procedural Terminology® (CPT®) codes and codes identified via the RUC's potentially misvalued services process. CMS also accepted and implemented a RUC recommendation to update clinical supply packages. While the CMS proposal for telemedicine will not recognize the new telemedicine office visits codes for Medicare payment, the RUC recommendations for these services are published without revision.

Clinical Labor Pricing Update

CY 2025 will be the fourth and final year of transition of the clinical staff wage increases. This inflationary update is budget neutral within the practice expense relative values, impacting those services with higher cost supplies and equipment the most severely, as illustrated in the CMS impact analysis. CMS finalized a multi-year transition to mitigate the impact of payment changes due to the clinical labor pricing update. CMS has requested comment on the frequency of future updates to the pricing of clinical labor, medical supplies, and medical equipment.

Potentially Misvalued Services

The positive 0.05 percent budget neutrality relative value unit (RVU) adjustment is partially due to the savings produced from the RUC's identification and [review of potentially misvalued services](#). For 2025, CMS received several comments identifying potentially misvalued services for review. CMS reviewed these comments and concluded that further review is necessary for the osteotomy of spine and fine needle aspiration. The RUC will consider these services in 2025.

Payment for Medicare Telehealth Services

New CPT Codes for Telemedicine Visits

For CY 2025, the CPT Editorial Panel adopted a new set of CPT codes to be used for telemedicine office visits and RUC recommended RVUs for these codes, which include eight codes for synchronous audio-video services, eight codes for synchronous audio-only services, and one code for an asynchronous service. The new codes are patterned after the in-person office visit codes with subsets for new patients and established patients and may be reported based on the level of medical decision making or total time on the date of the encounter. One additional new CPT code describes a brief virtual check-in encounter and is intended to replace code G2012 (*Brief communication technology-based service*) that has the same descriptor.

CMS proposes to publish the new CPT telemedicine visit codes and RVUs but not recognize them for telemedicine services provided to Medicare patients. The explanation in the rule is that CMS interprets section 1834(m) of the Social Security Act as only allowing it to pay for telemedicine services that are the same as services provided in-person and to pay the same rates regardless of the modality used. For Medicare patients, this means that physicians will need to continue to report the same codes as for in-person office visits and use modifiers indicating if the patient is in their home or if the service is audio-only. Unless Congress acts to extend the ability for patients to receive telehealth services in their homes, for which payment is made at the same rate as in-person office visits, then effective January 1, 2025, physicians will be paid the facility rate for telemedicine visits. CMS does propose to adopt and utilize the new CPT code for a brief virtual check-in as a replacement for G2012.

Expiration of Geographic and Originating Site Waivers

CMS highlights that current law allowing patients to receive telehealth services all over the country, not just in rural areas, and to receive these services in their home without having to go to a medical facility will expire at the end of 2024. Without further congressional action to extend these flexibilities, except for patients receiving mental health and/or substance use disorder services, most Medicare telehealth services will generally be available only when the patient is in a medical setting in a rural area.

Audio-only Coverage, Additions to Telehealth List, Lifting of Frequency Limits

CMS proposes a new permanent policy allowing audio-only telehealth services for services delivered to patients in their home if the physician is capable of using audio-video but the patient does not have or does not consent to video use. This is an expansion of the policy previously adopted that allowed audio-only services for patients

receiving telehealth for mental health conditions. Through 2025, CMS also proposes to continue lifting frequency limits on telehealth for subsequent inpatient and nursing facility visits and critical care consultations, as well as to not require physicians providing telehealth to report their home address. In addition, additions to the Medicare Telehealth Services List are proposed for pre-exposure prophylaxis (PrEP) for human immunodeficiency virus (HIV), home International Normalized Ratio (INR) monitoring, and caregiver training services.

Virtual Supervision

Since COVID-19, CMS has defined the physician's "immediate availability" for services that require direct supervision to include real-time audio and visual interactive telecommunications technology. The proposed rule would permit virtual direct supervision as permanent policy for a subset of services requiring direct supervision, while for others virtual direct supervision would continue to be allowed through December 31, 2025. CMS also proposes continuing its current policy through 2025 allowing teaching physicians to virtually supervise residents, but only when the service is furnished virtually (e.g., when the patient, resident, and teaching physician are all in separate locations).

Updates to Practice Expense Data Collection and Methodology

CMS will continue to delay implementation of the 2017-based MEI cost weights, pending the AMA's Physician Practice Information (PPI) Survey. This delay responds to AMA Advocacy to continue to use physician practice cost survey data in determining the MEI cost weights and the criticism by the AMA and national medical state and specialty organizations of the data sources and methodology proposed by CMS.

CMS explains that they have contracted with the RAND Corporation to analyze and develop alternative methods for measuring practice expense for implementation of updates to payment under the PFS. CMS states that they will "continue to study possible alternatives, and would include analysis of updated PPI data, as part of our ongoing work." CMS seeks comments on how they may continue work to improve the stability and predictability of any future updates, including recurring pricing updates for clinical staff, medical supplies, and medical equipment.

The AMA PPI Survey, a multi-year effort to measure physician practice costs and the direct patient care hours spent by physicians, is scheduled to conclude this summer. The AMA will continue to work with Mathematica to analyze the data collected throughout 2024, intending to share with CMS in early 2025.

Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-on for Infectious Diseases (HCPCS code GIDXX)

CMS believes "the timing is appropriate for establishing a payment rate for infectious disease physician services since the COVID-19 PHE has ignited a hypervigilance for infectious diseases." Therefore, the agency proposes a new add-on code to describe intensity and complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease performed by a physician with specialized training in infectious diseases. HCPCS code GIDXX would be separately reportable in addition to hospital inpatient or observation evaluation and management (E/M) codes and would describe service elements including disease transmission risk assessment and mitigation; public health investigation, analysis, and testing; and complex microbial therapy counseling and treatment. CMS proposes a work RVU of 0.89 based on the work RVU for HCPCS code GIDXX. CMS projects \$340k in total Medicare allowed charges for GIDXX in CY2025. CMS also requested that the CPT Editorial Panel consider a code to describe this service. Finally, the agency seeks comments about barriers to infectious disease physicians billing hospital inpatient and observation E/M services, particularly when they provide a consultation.

Payment for Caregiver Training Services

CMS proposes three new codes (GCTM1-3) for caregiver training for direct care services and supports, such as preventing decubitus ulcer formation, wound dressing changes, infection control, special diet preparation, and medication administration. Two new codes for caregiver behavior management and modification training are also proposed (GCTB1-2), and all the new services, as well as the existing CPT codes for caregiver training services (97550-52, 96202-03), would be added to the Medicare Telehealth List. CMS estimates \$8.4 million in total Medicare allowed charges for the five new codes in CY2025.

Office/Outpatient (O/O) E/M Visit Complexity Add-on Code

CMS previously finalized a policy that the E/M visit complexity add-on code is not payable when the E/M visit is reported with CPT Modifier -25, which denotes a significant, separately identifiable E/M visit by the same physician or other qualified health care professional on the same day as a procedure or other service. The agency is hearing concerns that nonpayment of the E/M visit complexity add-on code, G2211, when the E/M code is reported on the same day as a preventive immunization or other Medicare preventive service is disruptive to the way such care is usually furnished and contrary to CMS' policy objectives for establishing the add-on payment. CMS states it cannot conclude that its policy is disruptive to the way care is delivered based on an early analysis of claims data from the first few months of 2024, which shows relatively few Medicare preventive services being billed on the day preceding or following an office or outpatient E/M visit. However, CMS agrees that the current policy is not well-aligned with the agency's policy objective for establishing the add-on payment. Therefore, CMS proposes to amend its previously finalized policy not to allow payment of the add-on code when reported with Modifier -25 and to pay for the add-on code when the E/M visit is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. CMS does not assume any additional spending beyond its original utilization projections for G2211 associated with this new proposal for CY2025.

Advanced Primary Care Management (APCM) Services (HCPCS codes GPCM1, GPCM2, and GPCM3)

CMS proposes to incorporate some payment and service delivery elements from CMS Innovation Center models, including Comprehensive Primary Care Plus and Primary Care First (PCF), into three new APCM services, which could be furnished per calendar month, following the initial qualifying visit for new patients and obtaining patient consent. APCM services would include elements of existing care management codes, including chronic care management (CCM), transitional care management (TCM), and principal care management (PCM), as well as communication technology-based services (CTSB), including virtual check-in services. Unlike existing care management codes, CMS is proposing that the code descriptors for APCM services would not be time-based. In addition, unlike the current coding to describe certain CTSB services, CMS is proposing that APCM services would not include timeframe restrictions, which CMS has heard are administratively burdensome. For example, virtual check-in services cannot be billed when there is a related E/M service within the previous seven days. CMS proposes that APCM services could not be billed by the same practitioner or another practitioner within the same practice for the same patient concurrent with these other services: CCM, PCM, TCM, interprofessional consultation, remote evaluation of patient videos/images, virtual check-ins, and e-visits.

CMS estimates \$86 million in total Medicare allowed charges for GPCM1-GPCM3 in CY2025. However, the agency also simultaneously reduced the projected utilization for 20 existing service codes. For example, CMS reduced the utilization ratio for CPT codes 99490 and 99487 by 10.4 percent due to the introduction of GPCM1-GPCM3. Therefore, CMS asserted that "...the cost impact of this proposal is negligible and therefore it is not necessary to adjust the conversion factor under the PFS budget neutrality requirement." An AMA analysis table breaking out CMS' impact assumptions is attached to this summary report.

To bill for APCM services, CMS is requiring the following service elements and practice-level capabilities: 24/7 access to care and care continuity; comprehensive care management; patient-centered comprehensive care plan; management of care transitions; practitioner-, home- and community-based-organization coordination; enhanced communication opportunities; patient population-level management; and performance measurement. CMS does not propose that all elements included in the code descriptors for APCM services must be furnished during any given calendar month for which the service is billed but billing physicians must have the ability to furnish every service element. Participation in certain alternative payment models, including accountable care organizations, PCF, and Making Care Primary, satisfies some of the practice-level capabilities, such as population-level management and performance measurement. MIPS-eligible physicians must register for and report the Value in Primary Care MIPS Value Pathway (MVP) to satisfy the performance measurement service element to bill APCM services.

While the service descriptors are consistent across all levels of APCM, CMS proposes to stratify APCM codes into three levels based on certain patient characteristics that are broadly indicative of patient complexity and the consequent resource intensity involved in providing these services. CMS proposes the Level 1 APCM code for patients with one or fewer chronic conditions “because of the increased import and use of non-face-to-face interactions in advanced primary care even for patients with relatively fewer health needs, which has increased over time for several observable reasons... including continuing practices widely adopted during the COVID-19 pandemic.” CMS proposes the Level 2 APCM code for patients with two or more chronic conditions and notes that nearly four in five Medicare beneficiaries have multiple chronic conditions. Finally, CMS proposes the Level 3 APCM code for patients with Qualified Medicare Beneficiary (QMB) status and two or more chronic conditions. There are about 8.5 million QMBs, Medicare-Medicaid dually eligible enrollees. CMS is proposing to use a patient’s QMB status to identify patients with social risk factors that necessitate greater resource requirements to effectively furnish advanced primary care than people without such risk factors. Table 23 displays the approximate national payment rates for these codes using the 2024 conversion factor.

Code	Short Descriptor	Crosswalk Codes	CMS Proposed Work RVU	CMS Proposed PE RVU	CMS Proposed MP RVU	CMS Proposed Full RVU	Approximate National Payment Rate
GPCM1	APCM for patients with up to one chronic condition	99490	0.17	0.14	0.01	0.31	\$10
GPCM2	APCM for patients with multiple (two or more) chronic conditions	99490, 99439, 99487, 99489	0.77	0.72	0.05	1.54	\$50
GPCM3	APCM for QMBs enrollees with multiple chronic conditions	Calculated as a relative increase from GPCM2	1.67	1.57	0.12	3.36	\$110

Cardiovascular Risk Assessment and Risk Management

CMS proposes to build upon the CMS Innovation Center’s Million Hearts® model test, which coupled payments for cardiovascular risk assessment with cardiovascular care management, and [reduced mortality rates](#) by lowering heart attacks and strokes. Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment and risk management services are proposed starting in 2025 (new codes GCDRA and GCDRM). An ASCVD risk assessment would be performed with a visit and the output must include a 10-year estimate of the patient’s ASCVD risk. For patients at medium or high risk for CVS, ASCVD risk management services are proposed to include blood pressure management, cholesterol management, smoking cessation, and other elements. CMS estimates \$1.7 million in total Medicare allowed charges for GCDRA and GCDRM in CY2025.

Strategies for Improving Global Surgery Payment Accuracy

For 90-day global surgical packages, CMS proposes to require the use of the appropriate transfer of care modifier (modifier -54, -55, or -56) when a physician plans to furnish only a portion of the global package, including when there is a formal, documented transfer of care as under current CMS policy or an informal, non-documented but expected transfer of care. CMS believes this proposal “would prevent duplicative Medicare payment for post-operative care because the global surgical package payment would be adjusted based on the appended modifier, and payment for post-operative care would not be made both as part of a global surgical package and through separately billed E/M visits.” CMS seeks comment from interested parties, including the RUC, about how best to determine the appropriate payment proportions for the pre-operative, surgical, and post-operative portions of the global package.

CMS estimates that the proposed transfer of care policy change would result in a \$143.5 million reduction in total Medicare allowed charges for CY2025. An AMA analysis table breaking out CMS’ impact assumptions is attached to this summary report. CMS acknowledged that their analysis only included a relatively small set of codes (approximately 180 codes) even though this policy would apply to all 90-day global services. CMS noted that the subset of codes they used for their analysis account for about 73 percent of total Medicare 90-day global procedure volume.

The agency proposes coding and payment for an E/M add-on code (GPOC1) to capture the additional time and resources spent providing post-operative care by a physician who did not perform the surgical procedure and who has not been involved in a formal transfer of care agreement. CMS proposes that this code could be billed only once during the 90-day global period. CMS estimates \$320k in total Medicare allowed charges for GPOC1 in CY2025.

Certification of Therapy Plans of Care with a Physician Order

CMS proposes amendments to the certification and recertification regulations aimed at reducing administrative burdens for physicians, qualified health professionals (QHPs), and therapists. The amendments would introduce an exception to the requirement for a physician or QHP signature on therapist-established treatment plans at the initial certification stage. This exception would apply when a written order or referral from the patient’s physician is already on file, and the therapist has documented evidence that the treatment plan was transmitted to the physician within 30 days of the initial evaluation.

CMS is also soliciting comments on the need for a regulation a) addressing the amount of time during which the physician who has written an order for therapy services could make changes to the therapist-established treatment plan by contacting the therapist directly, and b) whether there should be a 90-day (or other) limit to the physician order extending from the order date to the first date of treatment/evaluation by the therapist.

Advancing Access to Behavioral Health Services

CMS proposes new coding and payment for safety planning interventions (SPI) for patients in crisis in a variety of settings, including those with suicidal ideation or at risk of suicide or overdose. Add-on code GSPI1 could be reported along with a visit or psychotherapy service when safety planning interventions are performed by the billing practitioner in a variety of settings. SPI can include assisting the patient in following a personalized safety plan, utilizing family members and friends to help resolve the crisis, contacting mental health professionals, and others. An additional monthly code, GFC11, would support specific protocols for follow-up telephone calls after discharge from the emergency department for a crisis encounter, as a bundled service covering four calls in a month. CMS estimates \$7 million in total Medicare allowed charges for these two new codes in CY2025.

Medicare also proposes three new G-codes for digital mental health treatment devices furnished under a behavioral health treatment plan of care. In addition, six G-codes are proposed to allow certain nonphysician mental health professionals to provide interprofessional consultations to help better integrate behavioral health treatment into primary care and other settings. CMS estimates \$1.2 million in total Medicare allowed charges for these nine new codes in CY2025.

Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services

CMS anticipates that its systems will be able to process claims submitted using the dental claim form 837D by January 1, 2025. CMS proposes that, effective January 1, 2025, a KX modifier would be required for all dental service claims inextricably linked to covered medical services on both the dental claim forms 837D and the professional claim forms 837P to demonstrate coordination between the dental and clinical professional. The agency seeks comments on whether to recommend use of the GY modifier in instances where a dental service does **not** meet Medicare coverage criteria. Also starting Jan. 1, 2025, CMS proposes to require diagnosis codes on 837D dental claim forms. Diagnosis codes are already required for 837P professional claim forms.

CMS proposes to add to the list of clinical scenarios under which Medicare payment may be made for dental services inextricably linked to covered services to include: (1) dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease; and (2) medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for beneficiaries with end-stage renal disease. CMS seeks information regarding dental services that may be inextricably linked to Medicare covered services in the treatment of diabetes, autoimmune diseases requiring immunosuppressive therapies, sickle cell disease, hemophilia, and services associated with furnishing oral appliances used for the treatment of obstructive sleep apnea.

Currently, dental services inextricably linked to covered services are priced by Medicare Administrative Contractors. In this rule, CMS seeks comment on potential sources of payment information for the pricing of dental services inextricably linked to other Medicare covered services.

Drugs and Biological Products Paid Under Medicare Part B

CMS is proposing to codify at § 414.904(e)(6) that, for radiopharmaceuticals furnished in a setting other than the hospital outpatient department, Medicare Administrative Contractors (MACs) shall determine payment limits for radiopharmaceuticals based on any methodology used to determine payment limits for radiopharmaceuticals in place on or prior to November 2003. This proposal is intended to eliminate confusion and ensure consistency in payment across regions by allowing MACs the flexibility to continue using historical pricing methodologies.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

The proposed CY 2025 FQHC productivity-adjusted market basket update is 3.5 percent. CMS also proposes to remove productivity standards for RHCs.

CMS proposes to require RHCs and FQHCs to bill the individual codes that make up the general care management HCPCS code, G0511, listed in Table 24. Payment rates would be the national non-facility PFS payment rate, updated annually based on total PFS amounts. RHCs and FQHCs could also continue billing add-on codes for additional time. CMS also proposes to require RHCs and FQHCs to use three new advanced primary care management service G-codes (GPCM1; GPCM2; GPCM3) in lieu of HCPCS code G0511, which would be paid in addition to the RHC all-inclusive rate (AIR) or FQHC prospective payment system (PPS) at the PFS non-facility rate.

CMS proposes to continue to delay the in-person visit requirement for mental telehealth services furnished by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026. CMS also proposes to continue to allow non-behavioral health visits to be furnished via telecommunication technology on a temporary basis under the same methodology it uses now, but seeks comment on an alternative that would pay telehealth services under the RHC AIR methodology and FQHC PPS.

Beginning July 1, 2025, CMS proposes to allow RHCs and FQHCs to bill for the administration of Part B preventive vaccines at the time of service, which would initially be paid like other Part B vaccine claims and would be annually reconciled via cost reports. RHC and FQHC providers could continue to bill HCPCS code M0201 for additional payments for in-home vaccine administration.

Lastly, CMS proposes to clarify that qualifying dental services furnished in an RHC or FQHC can be paid under the RHC AIR methodology or FQHC PPS and clarifies scenarios for when medical and dental visits furnished on the same day by an RHC or FQHC should be billed as one visit versus two.

RHC and FQHC Conditions for Certification and Conditions for Coverage (CfCs)

RHCs and FQHCs would continue to be required to provide primary care services to their patient populations, but CMS would no longer determine or enforce the standard of RHCs “being primarily engaged in furnishing primary care services” and would no longer consider the total hours of an RHC’s operation and whether a majority of those hours involve primary care services. However, RHCs cannot be rehabilitation agencies or facilities primarily for the care and treatment of mental diseases. CMS seeks input on the proposals’ potential impact on access to primary care services, behavioral health services, and specialty care services. CMS also proposes to remove hemoglobin and hematocrit (H&H) from the listed laboratory services that RHCs must perform directly and proposes to make language updates to reflect current laboratory techniques.

Medicare Diabetes Prevention Program (MDPP)

CMS proposes definitional changes to align MDDP and Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) standards and clarifies that MDPP suppliers can maintain either CDC’s longstanding “in-person” or the new “in-person with a distance learning component” requirement. CMS clarifies that MDPP make-up sessions can only be furnished using permitted modalities, i.e., distance learning and in-person delivery. To identify make-up sessions held on the same day as a regularly scheduled MDPP session, MDPP suppliers must append Modifier 79 on makeup session claims. For MDPP distance learning sessions, self-reported weights must be obtained during live, synchronous online video technology with the MDPP Coach, or two date-stamped photos and/or video recordings of the beneficiary’s weight, with the beneficiary visible on the scale. Lastly, CMS proposes several language changes to conform with previous rulemaking and proposes to eliminate the MDPP bridge payment given 2024 reforms to the MDPP payment structure.

Medicare Shared Savings Program (MSSP)

CMS proposes to establish a new “prepaid shared savings” option in which eligible accountable care organizations (ACOs) with a history of shared savings can be approved for advance shared savings they can use to invest in enhanced care services, care coordination, or infrastructure. CMS proposes a new health equity benchmark adjustment which would adjust upward an ACO’s historical benchmark based on the number of beneficiaries they serve who are dually eligible or enrolled in the Medicare Part D Low-Income Subsidy (LIS). The agency also proposes to clarify weighting policies for caps on risk score growth between the final base year and performance year.

CMS proposes a new methodology to account for improper payments in final expenditure calculations and payment amounts upon reopening a payment determination, as well as a methodology for excluding HCPCS and CPT codes exhibiting significant, anomalous, and highly suspect billing activity starting with the 2024 performance year.

CMS proposes to add new services to the list of primary care services used for beneficiary assignment to align with proposed coding changes. CMS also proposes to broaden the existing exception to the program's voluntary alignment policy to allow assignment to certain disease- or condition-specific Innovation Center models such as the Comprehensive ESRD Care Model to supersede voluntary MSSP assignment. CMS would no longer terminate an ACO's participation agreement if its population falls below 5,000. However, ACOs would still be subject to possible compliance action and be required to meet the minimum threshold of 5,000 assigned beneficiaries in order to begin a new participation agreement. CMS also proposes to align application procedures with the latest antitrust enforcement procedures.

CMS proposes to no longer make beneficiary follow-up communications contingent on an individual patient's last primary care visit. Instead, all follow-up communications must be within 180 days of the standardized written notice. Additionally, for ACOs under preliminary prospective assignment with retrospective reconciliation, mandatory notifications would also be limited to a population subset that is more likely to be assigned to the ACO (i.e., those who received at least one primary care service during the assignment window from an eligible primary care clinician in the ACO), rather than all fee for service beneficiaries.

Finally, CMS solicits comments on a potential higher risk-reward track that would replace the current ENHANCED track.

MSSP Quality

CMS is proposing to establish the APM Performance Pathway (APP) Plus quality measure set under the APP, which would be an optional measure set for MIPS eligible clinicians, groups, and APM Entities that participate in a MIPS APM but required for MSSP ACOs starting with the 2025 performance year. Therefore, the APP quality measure set would no longer be available for reporting by Shared Savings Program ACOs.

The APP Plus quality measure set would incrementally grow to comprise of 11 measures—consisting of the six measures in the existing APP quality measure set and five newly proposed measures from the CMS Adult Universal Foundation measure set that would be incrementally incorporated into the APP Plus quality set over performance years 2025, nine measures in performance years 2026 and 2027, and 11 measures in performance year 2028 and subsequent performance years. CMS intends to update the APP Plus quality measure set as new measures are added to or removed from the Adult Universal Foundation measure set in the future. ACOs would be required to report on all measures in the measure set annually.

CMS is also proposing to streamline the collection types available for MSSP ACOs reporting the APP Plus Quality measure set to focus on either reporting the measures as electronic clinical quality measures (eCQMs) or Medicare Clinical Quality Measure for ACOs collection types. Therefore, MIPS CQMs or the web-interface would not be an available collection type for reporting the APP Quality Measure set. CMS had already previously finalized that the 2024 performance period would be the last year ACOs would be able to report their quality measures through the web-interface and did not propose to extend it for the 2025 performance period.

When calculating MIPS Quality performance category scores, ACOs would be scored on all required measures in the APP Plus quality measure set using the APP scoring policies, and ACOs reporting Medicare CQMs would be scored using flat benchmarks for the measures' first two performance periods in MIPS.

To encourage APM Entities, MSSP participants, and virtual groups to report electronic clinical quality measures (eCQMs), starting in performance year 2025, CMS is proposing a complex organizational adjustment, which would add one measure achievement point for each submitted eCQM for an APM entity or virtual group that meets data completeness and case minimum requirements. The adjustment would not exceed 10 percent of the total available measure achievement points in the quality performance category.

Medicare Part B Payment for Preventive Services

Medicare Part B covers preventive vaccines for influenza, pneumonia, hepatitis B, and COVID-19, and there is no patient cost-sharing. For CY 2025, CMS proposes to expand coverage of hepatitis B vaccinations to all individuals who have not previously received a completed hepatitis B vaccination series or whose vaccination history is unknown. In addition, CMS would allow roster billing for this vaccine by mass immunizers such that a physician's order would no longer be required. Also, for the first time since the law allowing coverage of drugs as "additional preventive services" was enacted in 2008, CMS is proposing to pay for a drug in this benefit category which, like other Medicare preventive services, would have no cost-sharing. Specifically, CMS proposes to pay for pre-exposure prophylaxis (PrEP) for human immunodeficiency virus (HIV) infection prevention.

Expand Colorectal Cancer Screening

CMS is proposing to exercise its authority under section 1861(pp)(1)(D) to make significant adjustments in colorectal cancer (CRC) screening to promote access and remove barriers for much needed cancer prevention and early detection within rural and communities of color that are especially impacted by the incidence of CRC. In response to evidence supporting its efficacy and recommendations by the United States Preventive Services Task Force, CMS is proposing to introduce coverage for Computed Tomography Colonography. CMS is also proposing to broaden the definition of complete CRC screening in § 410.37(k) to include a follow-on screening colonoscopy after a positive result from a Medicare-covered blood-based biomarker test. Finally, CMS is proposing to eliminate coverage for the barium enema procedure.

Requirements for Electronic Prescribing for Controlled Substances (EPCS) for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan

CMS proposes to extend the requirement for controlled substance prescriptions for patients in long-term care facilities to comply with EPCS rules by three years, from 2025 to 2028. At that time, the new National Council for Prescription Drug Programs (NCPDP) SCRIPT standard version 2023011, which includes three-way communication functionality to improve communication between pharmacies and long-term care facilities, will also be required.

Medicare Parts A and B Overpayment Provisions of the Affordable Care Act

CMS proposes to specify circumstances under which the standard 60-day repayment deadline for reporting and returning overpayments may be suspended to allow time for providers to investigate and calculate overpayments. Under the proposals, the new deadline for returning the overpayment(s) will remain suspended until the investigation has concluded and the aggregate amount of overpayments is calculated, or 180 days after the initial overpayment was identified, whichever is sooner.

Payment of Skin Substitutes

CMS proposes that billing and payment codes for skin substitute products are not counted for identifying refundable drugs, continuing the policy from 2023 and 2024. CMS plans to revisit discarded drug refund obligations for skin substitutes in future rulemaking and proposes to codify the existing policy by including skin substitutes in the list of products not considered Part B rebatable drugs to create a consistent, transparent, and fair payment approach under Medicare.

Request for Information (RFI) for Services Addressing Health-Related Social Needs

CMS issues an RFI on the new Community Health Integration, Principal Illness Navigation, and Social Determinations of Health (SDOH) Risk Assessment services, including how to improve utilization in rural areas, how these services are being furnished in conjunction with community-based organizations, and opportunities to

increase coding of Z codes when social risk factors screen positive. CMS also seeks feedback about barriers to providing evidence-based care for persons with fractures and notes it has heard “there is a systemic disconnect on which provider and/or specialty is responsible for osteoporosis diagnosis and treatment.” CMS is interested in feedback about whether the proposed global period post-operative add-on code could help resolve these issues.

RFI: Advanced Primary Care Hybrid Payment

CMS seeks comments about whether and how the agency should consider additional payment policies that recognize the delivery of advanced primary care services. The agency requests input in the following five areas: streamlined value-based care opportunities; billing requirements; person-centered care; health equity, clinical and social risk; and quality improvement and accountability.

RFI: Building upon the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care

CMS issues an RFI soliciting feedback on the design of a potential ambulatory specialty care model that would leverage the MVPs with the purpose of increasing specialty engagement in value-based care and expanding incentives for primary and specialty care coordination. As currently conceptualized by CMS, participants under the model would receive, in lieu of an MIPS adjustment payment, a payment adjustment based upon a set of clinically relevant MVP measures and how they performed relative to other specialists of their same specialty type and clinical profile. If CMS were to propose a future model test, it would do so through notice and comment rulemaking. CMS also stated that if the agency were to propose to mandate the ambulatory specialty care model, the earliest it would do so would be 2026.

Quality Payment Program (QPP) Updates and Proposals

MIPS Performance Threshold

Following ongoing advocacy by the AMA not to increase the MIPS performance threshold due to significant disruptions caused by the COVID-19 pandemic and Change Healthcare cyberattack, CMS is proposing to maintain the threshold to avoid a MIPS penalty of up to nine percent at 75 points for the CY 2025 performance year/2027 MIPS payment year. [Research](#) continues to show that MIPS is unduly burdensome; disproportionately harmful to small, rural, and independent practices; exacerbates health inequities; and is divorced from meaningful clinical outcomes. The AMA is [strongly](#) urging Congress to make statutory changes to improve MIPS and address fundamental problems with the program by replacing steep penalties that disproportionately hurt small and rural practices, prioritizing access to timely and actionable data, reducing burden, aligning MIPS with facility quality programs, and incentivizing the development and reporting of new clinically relevant quality and cost measures.

MVPs

CMS proposes six new MVPs around the following topics: Complete Ophthalmologic Care, Dermatological Care, Gastroenterology Care, Optimal Care for Patients with Urologic Conditions, Pulmonology Care, and Surgical Care.

MVP Subgroup Reporting

As previously finalized, beginning in the 2026 performance period/ 2028 MIPS payment year, multispecialty groups who chose to report an MVP (not traditional MIPS) will not have the option to report an MVP at the group level, and instead would need to participate at the subgroup, individual, or (if applicable) alternative payment model (APM) entity level. CMS believes this change to group reporting for MVP-only participants will provide specialists within a multispecialty group the ability to more actively participate in the program by submitting an MVP, as opposed to the group reporting on the same measures across the multispecialty group.

MVP RFI

Within the rule, CMS includes an RFI on MVP readiness and the timeline to sunset traditional MIPS and require MVP reporting. CMS highlights that 2023 performance period was the first year for MVP reporting and subgroup reporting with 12 MVPs and since then, CMS has expanded the inventory of MVPs each year and estimates that 80 percent of specialties will have an applicable MVP in the 2025 performance period, if the current MVP proposals are finalized. Therefore, within the RFI CMS has identified the 2029 performance period as the potential timeline for completing the transition to MVPs and sunseting traditional MIPS.

CMS believes this timeline would ensure MVPs remain voluntary for the next several years and traditional MIPS is available— allowing clinicians time to prepare for MVP reporting and to engage in the development of the MVP inventory. However, CMS specifically highlights that any policy proposing to sunset traditional MIPS would go through comment and rulemaking and that adequate prior notice would be provided to clinicians to allow for system upgrades and changes to work processes to report MVPs.

CMS also highlights that over 750 groups and clinicians registered to report MVPs for the CY 2023 performance period/2025 MIPS payment year and is interested in learning from early MVP participants to understand any barriers that the practices encountered or overcame to enable MVP submission.

Lastly, the RFI seeks feedback on including the possibility of creating broadly applicable MVP(s) or other alternatives for clinicians with limited quality and cost measures; establishing subgroup composition criteria, including specific considerations for multispecialty small practices; and additional considerations for identifying the specialty composition of a group.

Quality Performance Category

MIPS

CMS is proposing 196 quality measures for the 2025 performance period. These proposals reflect:

- Addition of nine quality measures, including two patient-reported outcome measures.
- Removal of 11 quality measures from the MIPS quality measure inventory.
- Substantive changes to 66 existing quality measures.

Note that Qualified Clinical Data Registry (QCDR) measures are approved outside the rulemaking process and are not included in this total.

CMS is also proposing to maintain the data completeness threshold of 75 percent through the 2027 and 2028 performance periods for all available collection types. In addition, CMS proposes to modify the methodology it utilizes for scoring topped out measures from a single benchmark methodology that caps the total number of points that can be earned at seven to apply a flat benchmarking methodology to a subset of topped out measures. This proposal would only apply to topped out measures that are part of a specialty measures set with limited measure choice and have a high proportion of topped out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.

Furthermore, CMS proposes to modify its policy regarding multiple data submissions. Currently, CMS calculates and scores each submission received and assigns the higher of the scores but is proposing to score the most recent submission. The new submission would override a previous submission of the same submission type from the same organization. However, this proposal would not apply to different submission types by the same organization. For example, a small practice can report some quality measures through Medicare Part B claims, and some through a file upload.

Regarding MVPs, CMS is proposing to calculate all available population health measures for an MVP participant and to apply the highest scoring population health measure to their quality performance category score. If finalized, MVP participants would no longer be required to select a population health measure as part of their MVP registration.

APMs/MSSP

CMS is proposing to establish the APP Plus quality measure set under the APM Performance Pathway (APP), which would be an optional measure set for MIPS eligible clinicians, groups, and APM Entities that participate in a MIPS APM but required for MSSP ACO starting with the 2025 performance year. Therefore, the APP quality measure set would no longer be available for reporting by Shared Savings Program ACOs. For more details on the APP Plus quality measure set and incentives to report eCQMs for APMs, MSSP, or virtual group participants, see the MSSP section above.

Cost Performance Category

CMS proposes to add the following six episode-based cost measures beginning in 2025: Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, Rheumatoid Arthritis, and Respiratory Infection Hospitalization. The new measures would have a 20-episode case minimum. The agency proposes to modify the following episode-based cost measures: Cataract Removal with Intraocular Lens (IOL) Implantation (currently titled Routine Cataract Removal with IOL Implantation) and Inpatient (IP) Percutaneous Coronary Intervention (PCI) (currently titled ST-Elevation Myocardial Infarction (STEMI) PCI). The agency also proposes criteria for removing cost measures from the cost performance category.

In response to concerns about cost performance category scoring having a negative impact on physicians' final scores, CMS proposes to modify the methodology for scoring cost measures beginning with the 2024 performance period. Specifically, CMS would tie the median score to a point value derived from the performance threshold and assign points above and below the median based on a standard deviation. Lastly, CMS proposes to adopt a cost measure exclusion policy that would apply when CMS makes an error in calculating the cost measure which would result in a negative impact on the measure score.

Improvement Activities (IAs) Performance Category

CMS proposes to add two new population health IAs; modify two existing IAs; and remove eight IAs for the 2025 performance year. The two new IAs include "Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake" and "Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk." The full list of IAs can be found in Appendix 2.

CMS proposes to do away with "high" and "medium" weighting of IAs so that all traditional MIPS ECs (except for non-patient facing MIPS ECs, small practices, and practices located in rural areas and geographic HPSAs) must attest to completing two improvement activities to earn full credit for the IA category and all MVP reporters must attest to completing one improvement activity to earn full credit. ECs can also continue to satisfy IA requirements by participating in a PCMH. In order to avoid accidentally overriding re-weighting, CMS proposes that it would score the improvement activities category only if they receive an attestation to at least one improvement activity.

Promoting Interoperability (PI) Performance Category

CMS reiterated what was finalized in June 2024 in the [information blocking disincentives for health care providers rule](#), including revising the definition of "meaningful EHR User for MIPS" to state that a MIPS eligible clinician is not a meaningful EHR user for a performance period if HHS determines that clinician committed information blocking during the calendar year of the performance period, meaning that clinician would therefore be unable to earn a score (instead, earning a score of zero) for the PI performance category.

In addition, CMS noted that efforts were currently underway with Office of the National Coordinator for Health Information Technology (ONC) to update the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides), with updated versions of the guides potentially available as early as CY 2025, which could mean a change to this promoting interoperability measure in the CY 2026 performance period/2028 MIPS payment year. Moreover, CMS described how it intends to use this performance category for further advancements in the use of Fast Healthcare Interoperability Resources (FHIR) application programming interfaces and to promote cybersecurity best practices for MIPS-eligible physicians.

The agency also included an RFI on public health reporting and data exchange. In partnership with ONC and the CDC, CMS wants to explore how PI could advance public health infrastructure through more advanced use of health IT and data exchange standards. CMS noted how the COVID-19 public health emergency highlighted the interdependencies of public health and health care, and the importance of timely, integrated, and interoperable data exchange across the health ecosystem to protect the health and safety of patients, populations, and the broader public.

Calculating the Final Score

CMS proposes that beginning with the CY 2024 performance period/2026 MIPS payments year, the option for physicians to request reweighting of one or more of the performance categories (specifically, quality, IA, or PI) due to a MIPS eligible clinician's data being inaccessible or unable to be submitted due to circumstances outside of the control of the clinician. For CMS to make the determination, the information outlining the problem would need to be submitted to CMS on or before November 1 of the year preceding the relevant MIPS payment year.

Data Submission for the Performance Categories

CMS is proposing to codify its policy for minimum criteria for a qualifying data submission for a MIPS performance period for the quality, IA, and PI categories. Specifically, for the quality and IA performance categories, CMS is proposing that for multiple data submissions received from submitters in multiple organizations (e.g., a vendor and practice), CMS will calculate a score for each submission received and assign the highest scores. For multiple data submissions received from a submitter in the same organization, CMS will score the most recent submission. However, for quality this proposal would not apply to different submission types by the same organization. For example, a small practice can report some quality measures through Medicare Part B claims, and some through a file upload.

For the PI performance category, CMS is proposing to modify its policy that for multiple data submissions received, CMS would calculate a score for each data submission received and assign the highest of the scores.

Projected 2025 MIPS Participation and 2027 Payment Adjustments

CMS estimates there will be 686,645 MIPS eligible clinicians in the 2025 performance period, the median final score will be 86.42, and 78 percent of MIPS eligible clinicians will receive a positive payment adjustment. The increase in estimated final scores is largely due to CMS' proposal to modify the cost measure scoring methodology. For example, the median cost score increases from 59.16 under current policies to 73.85 based on proposed policies. However, even under the proposed policies, solo practitioners and small practices remain more likely to be penalized. CMS estimates 46 percent of solo practitioners and 21 percent of small practices will receive a penalty compared to 15 percent overall. This is also true for solo practitioners and small practices that qualify as safety net physicians, and those in rural areas. See the table below.

	Estimated median final score	Estimated percent receiving a penalty
All MIPS eligible clinicians	86.42	15%
All solo practitioners	75.00	46%
All small practices	86.02	21%
All rural practitioners	85.41	16%
Rural solo practitioners	75.00	46%
Rural small practices	87.34	20%
All safety net practitioners	88.59	14%
Safety net solo practitioners	65.78	52%
Safety net small practices	84.50	27%

CMS projects the median positive payment adjustment in the 2027 payment year based on 2025 performance will be 1.31 percent while the median penalty will be -1.48 percent. However, CMS expects that the median penalty will be -6.42 percent for solo practitioners and -5.88 percent for small practices because more solo practitioners and small groups are expected to receive the maximum -9 percent MIPS penalty.

Advanced APM Proposals

Under current law, Qualified APM Participant (QP) thresholds are set to increase in the 2025 performance year from 50 to 75 percent of payments and from 35 to 50 percent of patients. The partial QP thresholds will also increase from 40 to 50 percent of payments and 25 to 35 percent of patients. Under current law, Advanced APM lump sum bonuses are set to expire at the end of the 2024 performance year, but QPs in advanced APMs would still be eligible for a 0.75 percent conversion factor (in lieu of a 0.25 percent conversion factor for MIPS ECs), exemption from MIPS, and any model-specific performance payments.

CMS proposes to broaden the definition of “attribution-eligible beneficiary” to be based on covered professional services, as opposed to evaluation and management (E/M) services, so that the term can be consistently defined across all APMs including those that do not use E/M services as the basis for attribution and to help avoid any perverse incentives to favor primary care physicians over specialty physicians in Participation Lists.

Helpful links:

- The text of the proposed rule can be accessed [here](#)
- The CMS press release is available [here](#)
- The CMS fact sheet is available [here](#)
- The CMS fact sheet on the 2025 Quality Payment Program is available [here](#)
- The CMS fact sheet on the Medicare Shared Savings Program is available [here](#)