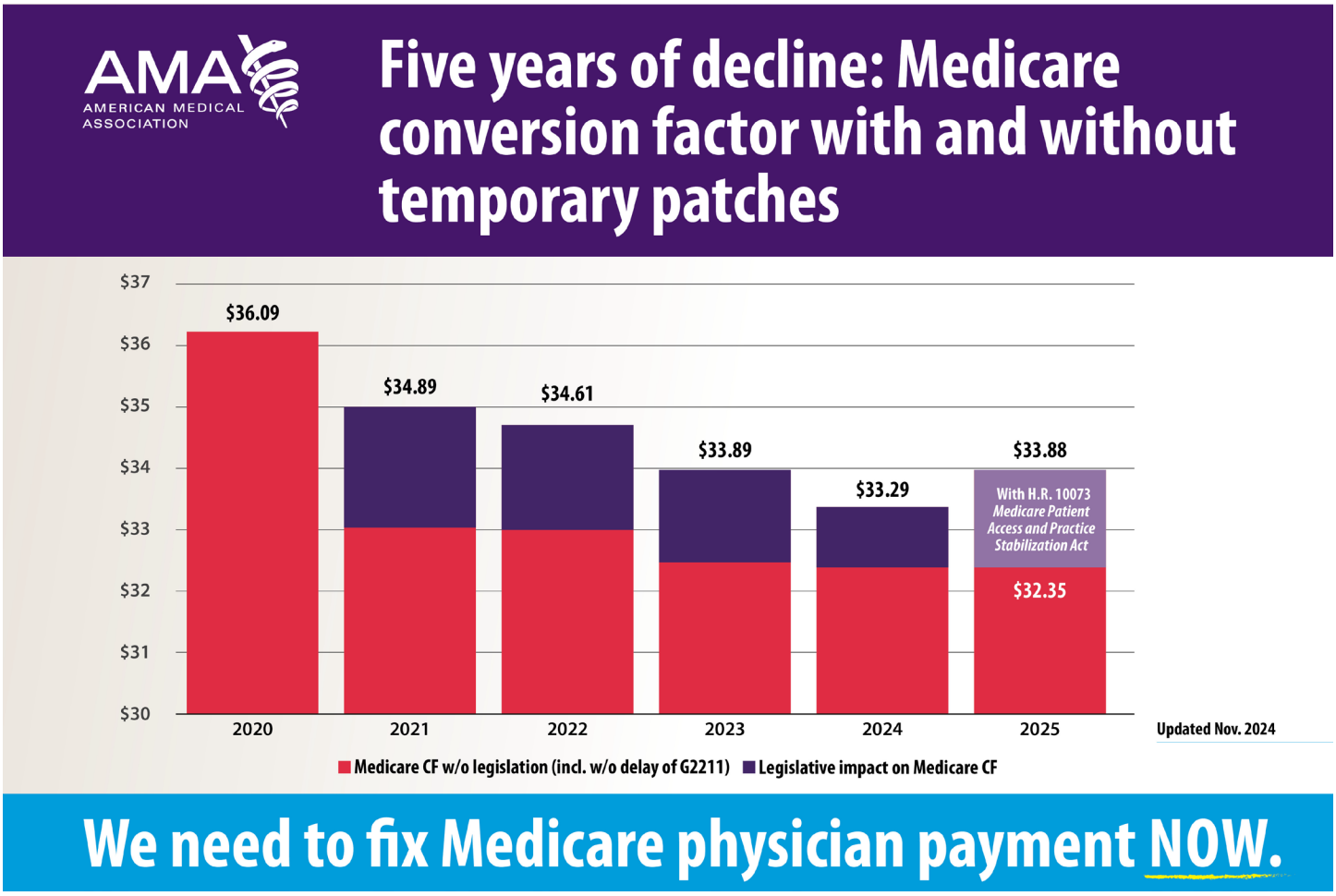
2025 Medicare Physician Payment Schedule (PFS) and Quality Payment Program (QPP) Final Rule Summary

On Nov. 1, 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 final rule. The rule includes proposals related to Medicare physician payment and the Quality Payment Program (QPP). These policies will take effect on January 1, 2025, unless otherwise noted.

Payment Updates and Proposals

CY 2025 Medicare Conversion Factor

The 2025 Medicare conversion factor will decrease for the fifth straight year by approximately 2.83 percent from $33.2875 to $32.3465. Similarly, the anesthesia conversion factor will be reduced from $20.7739 to $20.3178. This cut results from the expiration of a 2.93 percent temporary update to the conversion factor at the end of 2024 and a 0 percent baseline update for 2025 under the Medicare Access and CHIP Reauthorization Act. The graphic below depicts the decline in Medicare physician payment since 2020 and highlights the urgent need for congressional intervention before January 1.



Unfortunately, the 2025 cut coincides with ongoing growth in the cost to practice medicine as CMS has determined that the increase in the Medicare Economic Index (MEI) for 2025 is 3.5 percent. Physician practices cannot continue to absorb increasing costs while their payment rates dwindle. Both the Medicare Payment Advisory Commission 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 continues to grow. This is why the AMA and our partners in organized medicine are strongly supporting the bipartisan H.R. 10073, Medicare Patient Access and Practice Stabilization Act of 2024, which would stop the cut and increase physician payment rates by one-half of the MEI by applying a 12-month payment update of 4.73 percent. This bill comes on the heels of 233 bipartisan members of Congress (140 Ds, 93 Rs) cosigning a Dear Colleague letter to House leadership that requested the latest round of cuts be replaced with a payment update that reflects inflationary pressures on physician practices. We are urging all physicians to ask your representatives to cosponsor H.R. 10073.

Physician Work and Practice Expense Relative Value Changes

Relative Values

CMS accepted and will implement 91 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 inflation-based 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.

Potentially Misvalued Services

The positive 0.02 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 services. The RUC will consider these services in 2025.

Payment for Medicare Telehealth Services

For Medicare patients to be able to continue to access telehealth services all over the country, not just in rural areas, and have them delivered to their home without having to go to a separate originating site, Congress must act before the end of 2024 to extend the COVID-era waivers of geographic and originating site restrictions under current law. The final rule includes policies that improve telehealth access in multiple ways, however. Most importantly, after nearly five years of AMA advocacy, CMS has finalized a permanent change to its definition of interactive telecommunications system to include audio-only services, not just audio-video.

CMS has also extended for one year the ability to provide virtual direct supervision and virtual supervision of residents when the resident provides telehealth services. Frequency limits on subsequent hospital and nursing facility telehealth visits were lifted for one more year and physicians providing telehealth from their homes do not have to report their home address to Medicare.

CMS has adopted the new CPT code 98016 describing a brief communication technology-based service, which was previously reported with HCPCS code G2012. In a setback for medicine, however, CMS has finalized its decision to post the other new CPT telemedicine evaluation and management (E/M) codes and relative values but not to adopt them for use in Medicare. CMS acknowledges AMA comments that these codes should not be subject to Medicare's statutory definition of telehealth and thus should be able to be used for Medicare patient services without new legislation being enacted but says that it was not persuaded by them. The AMA also warned of confusion if other payers and potentially Medicare Advantage plans utilize the new, more precise CPT telemedicine codes but PFS services continue to be reported with codes for in-person office visits plus various modifiers to designate if they are audio-only, audio-video, and/or delivered to the patient's home. CMS states in the final rule that it will develop educational materials to assist in correct coding of telehealth services.

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, concluded in August. The AMA will continue to work with Mathematica to analyze the data collected throughout 2024, intending to share with CMS in early 2025.

Payment for Caregiver Training Services

CMS finalized its proposal for three new codes (G0541-G0543) 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. It also established two new codes for caregiver behavior management and modification training (G0539-G0540). All five services as well as the existing CPT codes for caregiver training services (97550-52, 96202-03) are being added to the Medicare Telehealth List on a provisional basis.

Advanced Primary Care Management (APCM) Services

CMS finalized its proposal to establish and pay for three new codes (HCPCS codes G0556, G0557, G0558) for monthly APCM services. APCM services 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, including virtual check-in services. Unlike existing care management codes, the code descriptors for APCM services are not time-based. In addition, unlike the current coding to describe certain CTSB services, APCM services do not include timeframe restrictions, which CMS has heard are administratively burdensome. CMS modified its concurrent billing restrictions proposal and will allow other specialists in the same group practice, other than the physician who is furnishing APCM services, to bill for services that are now considered bundled into APCM, such as CCM, PCM, and TCM.

CMS estimates $100 million in total Medicare allowed charges for G0556-G0558 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 G0556-G0558. 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."

Despite the AMA's concerns about the burdensome requirements to report the APCM codes and recommendation to tier payment based on the capabilities of the practice using the RUC's recommendations for a patient-centered medical home, CMS finalized the practice-level infrastructure requirements as proposed. CMS noted that the RUC recommendations for tiering APCM payment based on practice capabilities are inconsistent with CMS' goals to pay physicians who have already transitioned to an advanced primary care delivery model. Table 27 displays the approximate national payment rates for these codes using the 2024 conversion factor.

TABLE 27: Final APCM Bundled Codes and Valuation

Code	Short Descriptor	Reference Codes	CMS Work RVU	Approximate National Non-Facility Rate
G0556	APCM for patients with up to one chronic condition	99490	0.25	$15
G0557	APCM for patients with multiple (two or more) chronic conditions	99490, 99439, 99487, 99489	0.77	$50
G0558	APCM for QMBs enrollees with multiple chronic conditions	Calculated as a relative increase from G0557	1.67	$110

Cardiovascular Risk Assessment and Risk Management

CMS is building 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, by establishing two new codes (G0537-G0538) for Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment and risk management services. CMS agreed with AMA comments that the ASCVD risk assessment should not be required to be performed on the same date as a visit since the physician may need to first obtain the patient's test results. Output from the risk assessment must include a 10-year estimate of the patient's ASCVD risk. For patients at intermediate or high risk for CVD, ASCVD risk management services may include blood pressure management, cholesterol management, smoking cessation, and other elements.

Strategies for Improving Global Surgery Payment Accuracy

For 90-day global surgical packages, CMS finalized its proposal to require the use of modifier -54 when a physician plans to furnish only the surgical procedure 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. Appending this modifier will reduce the payment rate to reflect that the surgeon is not providing the post-operative portion of the service. The AMA raised concerns that applying a payment reduction to surgical codes billed using modifier -54 and the multiple procedure payment reduction (MPPR) would duplicate the reduction and be inappropriate because the MPPR already reduces the payment for the second and subsequent services to remove payment for post-operative care. Despite these objections, CMS will apply both payment reductions. CMS did not finalize any changes regarding the use of modifiers -55 and -56 for CY 2025. Modifiers -55 and -56 will continue to be reported exclusively in cases where there is a documented formal transfer of care.

CMS estimated that the finalized transfer of care policy change would result in a $150 million reduction in total Medicare allowed charges for CY2025. 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 finalized coding and payment for an E/M add-on code (G0559) 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. This code can be billed only once during the 90-day global period. CMS estimates $370k in total Medicare allowed charges for G0559 in CY2025.

Certification of Therapy Plans of Care with a Physician Order

CMS finalized proposed amendments to the certification and recertification regulations and proposed an exception to the physician/nonphysician practitioner (NPP) signature requirement for occupational therapy, physical therapy, and speech-language pathology established treatment plans for purposes of the initial certification in cases where a written order or referral from the patient's physician/NPP is on file and the therapist has documented evidence that the treatment plan was transmitted to the physician/NPP within 30 days of the initial evaluation. CMS amended the regulation at § 424.24(c) for those cases when a patient has a signed and dated order/referral from a physician/NPP for outpatient therapy services. CMS noted that a signed and dated order/referral from a physician/NPP combined with documentation of such order/referral in the patient's medical record, along with further evidence in the medical record that the therapy plan of treatment was transmitted/submitted to the ordering/referring physician or NPP, is sufficient to demonstrate the physician or NPP's certification of these required conditions. This is an exception to the initial certification and does not apply to recertification of therapy treatment plans.

Supervision Policy for Physical Therapists (PTs) and Occupational Therapists (OTs) in Private Practice

CMS finalized a regulatory change to allow for general supervision of physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) by PTs in private practice (PTPPs) and OTs in private practice (OTPPs) for all applicable physical and occupational therapy services. CMS now allows for general supervision of OTAs and PTAs by OTPPs and PTPPs, when the OTAs and PTAs are furnishing outpatient occupational and physical therapy services. CMS noted the licensure and patient safety protections that exist in this space and also commented that the majority of states allow OTs and PTs to provide general supervision of their respective OTAs and PTAs when furnishing occupational therapy and physical therapy services. The AMA is thankful that CMS specifically considered patient safety and licensure restrictions per AMA comments.

Advancing Access to Behavioral Health Services

CMS finalized a new code, G0560, to pay 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, which can be reported in 20-minute increments. 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. The SPI code is also being added to the telehealth list. An additional monthly code, G0544, is a monthly code intended to support four follow-up telephone calls after discharge from the emergency department or certain other settings for a crisis encounter.

CMS adopted three codes, G0552-G0554, for digital mental health treatment devices furnished under a behavioral health treatment plan of care. It also adopted six HCPCS codes that parallel the existing CPT codes for interprofessional consultations for use by certain nonphysician mental health professionals who CMS says cannot report the CPT codes with the goal of better integrating behavioral health treatment into primary care and other settings.

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

Medicare is generally precluded from covering dental services. However, in the CY 2023 PFS final rule, CMS codified that Medicare payment could be made when dental services are inextricably linked to and related and integral to the clinical success of other Medicare covered services. Since then, CMS has gradually added additional dental services to the list of Medicare covered services. In the 2025 final MPFS, CMS added two new service groupings to this list including (1) dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease (ESRD); 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 ESRD, with some modifications in the final rule to reflect the duration of dialysis services for the treatment of ESRD. In our comments, the AMA signaled appreciation for CMS' judicious approach to adding new Medicare-covered dental services. We recognized the important link between dental and physical health and acknowledged that dental services have an insignificant impact on overall spending and utilization under the MPFS thus far, while warning about the potential future impact on Medicare

payments as more dental services are potentially added. We urged the administration to find an alternative long-term vehicle for reimbursing dental services outside of the MPFS and urged frequent monitoring and transparency of the impact of covering dental services on overall Medicare physician payments in the interim.

CMS acknowledged logistical processing issues for dental claims and reiterated its ongoing efforts to rectify them. In response to feedback from the AMA and others, the agency finalized but delayed until July 1, 2025, two new requirements to report diagnosis codes on dental claim forms and to report the KX modifier on professional, dental, and institutional claim forms to identify dental services inextricably linked to covered medical services and to demonstrate coordination between the dental and clinical professional. The delayed implementation date will allow additional time for provider education, testing, and sorting out any workflow challenges, per recommendations from the AMA and other commenters. CMS also intends to release additional guidance and noted that existing frequently asked questions can be found at www.cms.gov/medicare/coverage/dental.

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

The final CY 2025 FQHC productivity-adjusted market basket update is 3.4 percent. CMS removed productivity standards for RHCs effective with cost reporting periods ending after December 31, 2024, and finalized its proposal to require that RHCs deliver primary care services, while no longer enforcing the explicit requirement that more than 50 percent of an RHC's operations must involve primary care services to allow for greater flexibility. The AMA expressed support for the enhanced flexibility both policies offered in our comments and CMS cited several AMA points in its explanation for finalizing the proposals. CMS did not finalize its proposal that RHCs cannot be rehabilitation agencies or facilities primarily for the care and treatment of mental diseases.

CMS will continue to allow payment for RHC and FQHC telehealth visits, further delayed the in-person visit requirement for mental telehealth services to beneficiaries in their homes, and will continue to allow virtual supervision through 2025. The AMA strongly supported continued telehealth flexibilities for RHCs and FQHCs.

CMS finalized requiring RHCs and FQHCs to individually bill general care management services including new advanced primary care management service G-codes, unbundling them from the all-inclusive rate (AIR), but will allow RHCs and FQHCs an additional six months (until July 1, 2025) to come into compliance. At the facility level, RHCs and FQHCs must report these services with G0511 or the individual codes, but not both.

Beginning July 1, 2025, CMS will allow RHCs and FQHCs to bill for the administration of Part B preventive vaccines at the time of service. RHC and FQHC providers may continue to bill HCPCS code M0201 for additional payments for in-home vaccine administration. Lastly, CMS clarified that when dental services meet RHC/FQHC physician setting operational requirements, they count as a qualifying visit and can be paid under the RHC AIR methodology or FQHC PPS and that RHCs and FQHCs can bill separately for covered dental services on the same day a medical visit is furnished.

Medicare Diabetes Prevention Program (MDPP)

CMS finalized definitional changes to align MDPP and Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) standards, in alignment with prior AMA comments. CMS clarified that MDPP suppliers can maintain either CDC's "in-person" or the new "in-person with a distance learning component" requirement but reiterated "online" nor "combination with an online component" delivery modes would apply to the MDPP despite AMA calls to include virtual-only suppliers as a way to expand the program's reach to additional beneficiaries.

In response to previous AMA feedback, CMS will allow MDPP make-up sessions to be held on the same day as a regularly scheduled MDPP session and will allow additional more flexible ways for participants to self-report weights for distance learning sessions, including through live, synchronous online video technology with the MDPP Coach, or by sending one or two date-stamped photos and/or video recordings picturing the beneficiary's weight and the beneficiary in his or her home. In response to the AMA's recommendation that metadata be allowed to count

towards meeting the "date stamped" requirement, CMS stated that it is "relying on MDPP suppliers to ensure a reasonable and reliable indication of the date connected to a picture or video" but recognizes that "in some cases a technological solution may meet these criteria."

CMS is currently allowing an exception to the once per lifetime limit for MDPP beneficiaries to restart their MDPP program if their services were interrupted by the PHE for COVID-19 and will "continue to monitor use of this flexibility to approximate the demand for beneficiaries to restart their program for other reasons" but did not finalize any at this time. The AMA has repeatedly called for CMS to remove the once-per-lifetime cap. Lastly, CMS eliminated the MDPP bridge payment given 2024 reforms to the MDPP payment structure, which were made in response to previous AMA feedback.

Medicare Shared Savings Program (MSSP)

CMS established a new methodology for excluding codes exhibiting significant, anomalous, and highly suspect (SAHS) billing activity impacting MSSP financial calculations to be applied retroactively starting with the 2024 performance year. The AMA strongly supported this change which was in response to an improper payment issue the AMA had previously helped to raise to CMS' attention regarding catheter supplies. In a September 2024 final rule, CMS excluded payment amounts for two catheter HCPCS codes (A4352 and A4353) on claims used for assessing performance year 2023 financial performance and benchmarks. CMS notes that SAHS activity will have a "high bar" and expects it to be a "rare occurrence" noting that the catheter issue was the first in the program's 12-year history. In response to AMA's request to monitor for spending issues at the regional level, CMS says it will consider whether the observed billing activity has "national or regional impact or significance." In our comments, the AMA also urged CMS to consider extending this new SAHS billing policy to MIPS participants.

CMS also finalized a separate methodology to account for improper payments in an Accountable Care Organization's (ACO's) financial calculations, including payment determinations and historical benchmarks, and established a process for ACOs to submit reopening requests, though CMS will ultimately determine whether to reopen a payment determination based on multiple factors. The timing of an ACO's reopening request must be either (i) at any time in the case of fraud, or (ii) within 4 years of the date of the initial determination of savings or losses for the relevant performance year for good cause, meaning this policy could apply to performance years prior to 2025. Additional guidance is forthcoming. The AMA strongly supported these policies, agreeing it would help protect the accuracy, fairness, and integrity of MSSP financial calculations.

CMS established a new "prepaid shared savings" option in which eligible ACOs with a history of shared savings can be approved for advance shared savings to invest in enhanced care services, care coordination, or infrastructure. These payments would be distributed on a quarterly basis and would be recouped from shared savings. Despite calls for additional flexibility, CMS finalized the requirement that at least 50 percent of their prepaid shared savings must be spent on direct beneficiary services. While the agency is not expanding eligibility criteria to new ACOs at this time to mitigate risk, it expressed an openness to doing so in the future pending results. In response to AMA feedback, CMS is making a one-time exception to allow ACOs to elect to begin receiving prepaid shared savings in 2026 without renewing their participation agreements.

CMS finalized a new health equity benchmark adjustment (HEBA) which would upwardly adjust an ACO's historical benchmark based on the number of beneficiaries it serves who are dually eligible or enrolled in the Medicare Part D Low-Income Subsidy (LIS). In response to feedback from the AMA and other interested parties, CMS broadened the applicability of the HEBA to ACOs have at least 15 percent of their assigned beneficiaries enrolled in LIS or dually eligible, as opposed to 20 percent as was proposed. This change will increase the number of eligible ACOs by 60 percent.

CMS added new services to the list of primary care services used for beneficiary assignment to align with coding changes, but did not finalize the addition of several interprofessional consult codes. Moving forward, assignment to certain disease- or condition-specific Innovation Center models such as the Comprehensive ESRD Care Model will supersede voluntary MSSP assignment. CMS will no longer terminate an ACO's participation agreement if its population falls below 5,000, but ACOs will still be subject to possible compliance action and required to meet the

minimum threshold of 5,000 assigned beneficiaries to begin a new participation agreement. CMS agreed with AMA comments that it is appropriate to consider ACOs' individual circumstances when determining compliance enforcement.

Moving forward, mandatory beneficiary follow-up communications for ACO-assigned beneficiaries will no longer be required prior to individual patient's primary care visit. Instead, all follow-up communications must be within 180 days of the standardized written notice sent at the beginning of the year. This is to promote more standardization and flexibility and reduce burden on practices to send notifications prior to visits. Additionally, for ACOs under preliminary prospective assignment with retrospective reconciliation, mandatory notifications will 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 FFS beneficiaries. The AMA was generally supportive of both proposals; however, the AMA suggested that follow up notifications be sent after a patient visit to maximize effectiveness which the agency did acknowledge but still finalized its proposed policy of 180 days after the initial notice.

In the proposed rule, CMS solicited comments on a potential higher risk-reward track that would replace the current ENHANCED track. CMS notes in the final rule that although many commenters were supportive of a higher risk track, nearly all commenters, including the AMA, were opposed to a higher risk track replacing the existing ENHANCED track. The AMA also took the opportunity to reiterate our strong opposition to mandatory tracks or models. CMS says it will consider all comments in future rulemaking.

In the 2024 MPFS, CMS finalized new policies impacting MSSP ACOs whereby all ACOs regardless of track must report MIPS Promoting Interoperability (PI) data. CMS also changed the certified electronic health record technology (CEHRT) threshold for all Advanced APMs from 75 percent to "all" eligible clinicians (ECs), with model-specific exclusions based on clinical criteria permitted. The AMA strongly opposed these changes and has been working with the administration over the last year to mitigate the negative impacts of both policies on physician participation in APMs. The AMA was successful in having CMS clarify through guidance to ACOs that: the MIPS small practice exclusion would apply to this policy; Realizing Equity, Access, and Community Health (REACH) ACOs must attest to using CEHRT for 90 days, as opposed to a full year; and PI data would not impact an ACO's shared savings calculations. The AMA is seeking additional guidance from the administration regarding possible further exclusions and enforcement flexibility, calling on the administration to set a corrective action-based approach to enforcement.

MSSP Quality

Although the AMA urged CMS to re-evaluate its proposal for establishing an additional quality measure set under the APM Performance Pathway (APP), called the APP Plus measure set, and making it mandatory for MSSP ACOs starting with the 2025 performance year, CMS finalized the policies as proposed. The AMA flagged that the new measure set adds additional administrative burden and is premature given the timing and the number of quality changes already finalized for the MSSP program. The APP Plus quality measure set would incrementally grow to comprise 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. 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. However, the APP Plus quality measure set under the APP will remain optional for MIPS ECs, groups, and APM Entities that participate in a MIPS APM.

Due to AMA advocacy, CMS finalized with modification the following collection types available for MSSP ACOs reporting the APP Plus quality measure set:

- The electronic clinical quality measure (eCQM) and Medicare CQM collection types will be available for the CY 2025 performance period and subsequent performance periods.
- The MIPS CQM collection type will remain as an option for MSSP ACOs and available for two additional years (i.e., the CY 2025 and 2026 performance periods/2027 and 2028 MIPS payment years). MIPS CQMs

will not be available to MSSP ACOs reporting the APP Plus quality measure set beginning in the CY 2027 performance period/2029 MIPS payment year.
- Despite strong advocacy by the AMA, CMS moved forward with its finalized policy to sunset the web-interface at the end of performance year 2024. Therefore, MSSP ACOs must report quality measures starting in 2025 either through eCQM, Medicare CQM or MIPS CQM collection types.

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 eCQMs starting in performance year 2025, CMS finalized the complex organizational adjustment policy, which adds one measure achievement point for each submitted eCQM for an APM entity or virtual group that meets data completeness and case minimum requirements. The AMA supported this incentive but urged CMS to consider applying the policy to ALL MIPS participants that report eCQMs. The adjustment will 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 is expanding 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. CMS will also 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 will pay for a drug in this benefit category which, like other Medicare preventive services, will have no cost-sharing. Specifically, CMS will begin paying for pre-exposure prophylaxis (PrEP) for human immunodeficiency virus (HIV) infection prevention. A new code, G0012, will cover PrEP for HIV prevention injections and two new codes, G0011-G0013, will pay for counseling individuals on PrEP to prevent HIV.

CMS finalized its proposal to remove the requirement that the administration of the hepatitis B vaccine be preceded by a physician's order. Under the new policy, an assessment of an individual's vaccination status can now be made without the clinical expertise of a physician. Therefore, a physician's order will no longer be necessary for the administration of a hepatitis B vaccine under Part B.

Expand Colorectal Cancer Screening

The AMA supported and CMS finalized its proposals to expand coverage of colorectal cancer (CRC) screening to promote access and remove barriers for much needed cancer prevention and early detection, particularly 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 established coverage for Computed Tomography Colonography. CMS also broadened the definition of complete CRC screening in § 410.37(k) to include a follow-on screening colonoscopy with no patient cost-sharing after a positive result from a Medicare-covered blood-based biomarker test. Finally, CMS eliminated 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 finalized its proposal 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. The purpose of this extension, which AMA comments supported, is to align the timeline for EPCS in long-term care facilities with requirements for 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.

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

CMS specified that the standard 60-day repayment deadline for reporting and returning overpayments may be suspended in certain circumstances to allow time for providers to investigate and calculate overpayments. Under this new policy, 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. The AMA strongly supported modifying the standard 60-day repayment deadline to provide additional flexibility for physician practices.

Additional Policies and Requests for Information (RFIs)

CMS also finalized the following policies:

- Coding and payment for hospital inpatient/observation E/M visit complexity add-on code for infectious diseases (HCPCS code G0545).
- Payment for the office/outpatient E/M visit complexity add-on code (HCPCS code G2211) when the E/M code is reported by the same physician or qualified health care professional (QHP) on the same day as an Annual Wellness Visit, vaccine administration, or other Medicare preventive service. This is a change from current policy which does not allow payment for G2211 when E/M visits are provided by the same physician or QHP to the same patient on the same day as another service and billed with CPT Modifier -25.
- Clarification that for radiopharmaceuticals furnished in a setting other than the hospital outpatient department, Medicare Administrative Contractors must 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 methodology may include, but is not limited to, the use of invoice-based pricing.

CMS thanked interested parties for their feedback on numerous RFIs, including those listed below that the AMA commented on, and stated that the agency will consider comments in future rulemaking.

- RFI for Services Addressing Health-Related Social Needs, which included a request for comment about care for people with fractures and osteoporosis
- Advanced Primary Care Hybrid Payment RFI
- RFI on Building upon the Merit-based Incentive Payment System (MIPS) Value Pathways Framework to Improve Ambulatory Specialty Care
- MVP Adoption and Subgroup Participation RFI

Quality Payment Program (QPP) Updates and Proposals

MIPS Performance Threshold

Following ongoing advocacy by the AMA that CMS should not increase the Merit-based Incentive Payment System (MIPS) performance threshold due to significant disruptions caused by the COVID-19 pandemic and Change Healthcare cyberattack, CMS will maintain the threshold to avoid a MIPS penalty of up to 9 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; exacerbating health inequities; and 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 eliminating 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

Despite strong AMA advocacy for MVPs to be stratified by condition and requesting modifications to new and existing MVPs, CMS finalized six new MVPs around the following topics without major changes: Complete Ophthalmologic Care, Dermatological Care, Gastroenterology Care, Optimal Care for Patients with Urologic Conditions, Pulmonology Care, and Surgical Care. CMS also finalized limited modifications to the previously finalized MVPs, including the consolidation of two neurology-focused MVPs into a single neurological MVP.

MVP participants will no longer have to select a population health measure at the time of MVP registration given population health measures are calculated based on administrative claims. To ease reporting burden, CMS will now automatically score the physician or group on the population health measure they perform best on. If reporting MVP as a subgroup, CMS will only score the overall group on one population health measure and the measure the overall group performs best on.

MVP Subgroup Reporting

Despite AMA advocacy against mandatory MVP subgroup reporting, CMS maintained its previously finalized policy that beginning with 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 must participate at the subgroup, individual, or (if applicable) 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 a singular set of measures.

Quality Performance Category

MIPS

CMS finalized a total of 195 quality measures for the 2025 performance period/2027 payment year. Within the set of available quality measures, CMS finalized, with modification, the addition of seven new quality measures and finalized, with modification, the removal of 10 quality measures. CMS also finalized substantive changes to 66 quality measures. Note that Qualified Clinical Data Registry (QCDR) measures are approved outside the rulemaking process and are not included in this total.

CMS also finalized its proposal to maintain the data completeness threshold of 75 percent through the 2028 performance period for all available collection types, which the AMA supported. In addition, CMS finalized its proposal 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 and lifted the cap. While the AMA supported the proposal, the AMA urged CMS to extend the policy to ALL topped-out measures. Limiting the policy to a select set of measures adds complexity to the program, is subjective, and favors some specialties over others.

APMs/MSSP

CMS finalized its proposal to establish the APP Plus quality measure set under the APP, which is an optional measure set for MIPS ECs, groups, and APM Entities that participate in a MIPS APM but required for MSSP ACO starting with the 2025 performance year. To meet the reporting requirements of the APP Plus quality measure set, all measures in the APP Plus quality measure set for a year must be reported. Therefore, the APP quality measure set would no longer be available for reporting by MSSP 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

Despite the AMA's concerns that these cost measures may have unintended consequences, including exacerbating health inequities, CMS finalized its proposal 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 will have a 20-episode case minimum. The agency also modified the 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 AMA is pleased that the agency finalized criteria for removing cost measures from the cost performance category, although we are disappointed that CMS did not apply those criteria to remove the highly problematic Total Per Capita Cost measure as we recommended.

In response to concerns from the AMA about the cost performance category scoring having a negative impact on physicians' final scores, CMS finalized its proposal to modify the methodology for scoring cost measures beginning with the 2024 performance period, with an aim of increasing the scores of MIPS ECs who deliver care at an average cost near the median. Physicians' scores on cost measures have generally been lower than scores for other MIPS measures, and the AMA has raised a fairness concern as not all MIPS ECs are scored on cost measures. Lastly, the AMA supported and CMS adopted 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. The AMA has pointed out numerous errors in the calculation of the MIPS cost measures, which negatively impact physicians' MIPS scores and Medicare payment rates.

Improvement Activities (IAs) Performance Category

CMS eliminated the "high" and "medium" weighting of IAs and reduced the total number of IAs required so that all MIPS ECs that do not qualify for automatic IA credit or are otherwise exempt must attest to completing two improvement activities to earn full credit for the IA category. MVP reporters would only have to attest to completing one improvement activity to earn full credit as a way to incentivize MVPs. The AMA supported both proposals, which reduces reporting burden on MIPS ECs. To avoid accidentally overriding re-weighting, CMS will only score the improvement activities category if they receive an attestation to at least one improvement activity.

CMS also added two new population health IAs and modified two existing IAs. 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." CMS initially proposed to remove eight IAs for the 2025 performance year, but following feedback from the AMA, delayed removing four more "substantive" activities until 2026 to allow clinicians time to plan and budget for selecting alternative activities to report. Despite AMA objections, CMS will also limit IA_BE_4 entitled "Engagement of Patients through Implementation of New Patient Portal" to clinicians who were not previously using a patient portal. However, in response to concerns raised by the AMA including that 21 percent of MIPS ECs currently report this IA, the agency delayed this change until 2026 to allow additional time for practices to plan and select another IA. The full list of 2025 IAs can be found in Appendix 2.

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 EC 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 the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/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 ASTP/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.

Data Submission for the Performance Categories

CMS finalized its proposal 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 finalized 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, which the AMA did not support due to the complexity of the policy and the need to have consistent policy across categories. However, for quality the policy 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 finalized its policy that for multiple data submissions received, CMS will 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 ECs in the 2025 performance period, the median final score will be 86.42, and 78 percent of MIPS ECs will receive a positive payment adjustment. The increase in estimated final scores is largely due to CMS' finalized policy 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 final rule policies. However, 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 update (in lieu of a 0.25 percent conversion factor update for MIPS ECs), exemption from MIPS, and any model-specific performance payments. The AMA is urging Congress to pass the Value in Healthcare Act (H.R. 5013/S. 3503), which would extend the Advanced APM bonus and freeze the QP payment threshold for two additional years.

CMS previously finalized a change to the CEHRT utilization threshold for achieving QP status in an Advanced APM from 75 percent to "all" ECs effective Jan. 1, 2025. Model-specific exceptions will be permitted for clinical reasons. CEHRT criteria was also permitted to be more flexible specific to the needs of each model. The AMA has been pushing for additional guidance and working to mitigate the potential negative effects of this new policy on physician participation in Advanced APMs. As part of these efforts, the AMA was able to secure a CEHRT attestation window of 90 days, as opposed to a full year, for REACH ACOs to allow additional time to come into compliance. The AMA is also urging CMS to take a corrective action-based approach to compliance.

CMS considered but ultimately did not finalize a proposal to broaden the definition of "attribution-eligible beneficiary" to be based on covered professional services, as opposed to 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. The change was intended to help avoid any perverse incentives to favor primary care physicians over specialty physicians in Participation Lists; however, the agency reversed this proposal after the AMA called for additional information regarding the change's potential variable impact on QP status across models. CMS stated in the final rule that "the effects of the proposed policy within [non-Kidney] Advanced APMs were more mixed and clustered closer to neutral" and that its "continued analysis suggested that there may be more work to be done in this area." The agency states it will propose a comprehensive approach to QP determination in future rulemaking, including a strategy to address the needs of condition-specific models.

Helpful links:

- 2025 MPFS/QPP Final Rule
- CMS Press Release
- Physician Payment Schedule Fact Sheet
- Medicare Shared Savings Program Fact Sheet
- Quality Payment Program (QPP) Fact Sheet