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ACEP's First Take from the Combined 2025 Medicare Physician Fee Schedule (PFS) and MACRA Quality Payment Program (QPP) Proposed Rule

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released a Medicare annual payment rule for calendar year (CY) 2025 that impacts payments for physicians and other health care practitioners. The rule combines proposed policies for the Medicare physician fee schedule (PFS) with those for the Quality Performance Program (QPP)—the quality performance program established by the Medicare Access and CHIP Reauthorization Act (MACRA). The final rule finalizes most of the proposals that were included in the CY 2024 PFS proposed rule released on July 9, 2024. ACEP submitted a comprehensive response to that proposed rule on September 9, 2024.

Below is a high-level summary of key policies, separated by PFS and QPP final policies.

Physician Fee Schedule

- **Conversion Factor:** By factors specified in law, average payment rates under the PFS will be reduced by 2.93% in CY 2025, compared to the average amount these services were paid for most of CY 2024. The change to the PFS conversion factor incorporates the 0% overall update required by statute, the expiration of the temporary 2.93% increase in payment for CY 2024 required by statute, and a relatively small estimated 0.02% adjustment necessary to account for changes in work relative value units (RVUs) for some services. This amounts to an estimated CY 2025 PFS conversion factor **of $32.35, a decrease of $0.94 (or 2.83%) from the current CY 2024 conversion factor of $33.29.**

Conversion factors	CY 2024 CF	CY 2025 CF	Difference	Percent Cut
Proposed 2024 CF	33.2875	32.3465	-0.94	-2.83

This is the fifth straight year that CMS has finalized a cut to the Medicare conversion factor. While total Medicare reimbursement for emergency physicians depends on the mix of services that they bill, in general emergency physicians will experience the full 2.83% cut to Medicare payments next year unless Congress steps in and enacts a fix.

- **Evaluation and Management (E/M) Visits:** Last year, CMS added a new complexity add-on code G2211. Based on feedback the agency received, CMS is finalizing a slight expansion in the use of this code when the office and outpatient (O/O) E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.
- **Telehealth**

New Telemedicine E/M Services: CMS reviewed the 17 new telemedicine E/M services in response to action taken at the Current Procedural Terminology (CPT) Editorial Panel's February 2023 meeting to revise the codes and guidelines for reporting E/M services delivered via telehealth. However, CMS is not adopting new telemedicine E/M services.

Other telehealth provisions finalized include:

- Continuation of the definition of "direct supervision" to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025, and proposal to permanently define "direct supervision" to include audio-video communications technology for a subset of services ((1) services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'; and (2) services described by CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional); and
- Allowing teaching physicians to use audio/video real-time communications technology when the resident furnishes Medicare telehealth services in all residency training locations through the end of CY 2025.

- **Behavioral Health Services:** CMS proposed to establish separate coding and payment under the PFS describing safety planning interventions for patients in crisis, including those with suicidal ideation or at risk of suicide or overdose. Specifically, CMS proposed to create an add-on G-code that would be billed along with an E/M visit or psychotherapy service when safety planning interventions are personally performed by the billing practitioner in a variety of settings. CMS is finalizing the code as a standalone code that can be billed in 20-minute increments.

  Additionally, CMS is finalizing its proposal to create a monthly billing code that requires specific protocols in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the emergency department for a crisis encounter, as a bundled service describing four calls in a month.

- **Urgent and Acute Care Request for Information (RFI):** CMS solicited feedback about capacity and workforce issues in relation to acute care and sought comment on when it may be appropriate to receive care in an urgent care clinic rather than an ED in the proposed rule. CMS thanks commenters for their responses, but does not finalize any policies in the final rule.

- **Opioid Treatment Programs (OTPs):** CMS is finalizing its proposal to make permanent the current flexibility for furnishing periodic assessments via audio-only telecommunications beginning January 1, 2025, so long as all other applicable requirements are met. CMS is also allowing the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone (using HCPCS code G2076) if the OTP determines that an adequate evaluation of the patient can be accomplished via an audio-visual telehealth platform.

  CMS is also finalizing payment increases in response to recent regulatory reforms for OUD treatment finalized by SAMHSA at 42 CFR part 8, including updating payment for intake activities furnished by OTPs to include payment for social determinants of health risk assessments to adequately reflect additional effort for OTPs to identify a patient's unmet health-related social needs or the need and interest for harm reduction interventions and recovery support services that are critical to the treatment of an OUD.

- **Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-on for Infectious Diseases:** For CY 2025, CMS is finalizing a new add-on code to describe the 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. The new code will describe service elements, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment.

- **Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan:** CMS is continuing to implement a provision of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, which requires electronic prescribing of controlled substances (EPCS) under Medicare Part D. CMS will continue its current policy of not instituting any financial penalties for non-compliance. Rather, CMS will issue a notice of non-compliance as a non-compliance action until January 1, 2028.

- **Dental and Oral Health Services:** CMS proposed to add to the list of clinical scenarios under which FFS 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 is finalizing the proposal with modification to include dental or oral examination performed as part of a comprehensive workup prior to, or contemporaneously with, Medicare-covered dialysis services when used in the treatment of ESRD; and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services when used in the treatment of ESRD.

  CMS also proposed and finalized two policies related to billing of dental services inextricably linked to covered services, to require the submission of the KX modifier on claims for dental services that clinicians believe to be inextricably linked to covered medical services beginning in CY 2025; and to require the submission of a diagnosis code on the 837D dental claims format beginning January 1, 2025.

Quality Payment Program

CMS finalized policies that impact the 2025 performance year in the Quality Payment Program (QPP). The QPP includes two tracks: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. Performance on these four categories (which are weighted) roll up into an overall score that translates to an upward, downward, or neutral payment adjustment that providers receive two years after the performance period (for example, performance in 2025 will impact Medicare payments in 2027).

- **MVPs:** The 2025 performance year is the third year in which a new reporting option in MIPS called MIPS Value Pathways (MVPs) is available. MVPs represent an approach that will allow clinicians to report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. ***ACEP developed an emergency medicine-focused MVP that became available in 2023.***

  In this year's rule, CMS is adding 1 quality measure and remove quality measures from the Emergency Medicine MVP. CMS proposed to add 1 improvement activity, remove 1 improvement activity, and remove the weights associated with the improvement activities

contained in this MVP. In the final rule, CMS did not finalize modification of IA_BE_4: Engagement of patients through implementation of improvements in patient portal and delayed the removal of IA_CC_2: Implementation of improvements that contribute to more timely communication of test results.

CMS also added 6 new MVPs. CMS has repeatedly stated that it intends to phase out traditional MIPS and transition fully to MVPs. In other words, MVPs would become mandatory rather than voluntary. While CMS had not previously laid out a specific timeline for making this transition, CMS issued an RFI in the proposed rule seeking comments on sunsetting traditional MIPS and making MVPs mandatory by 2029. This sunset date was a comment solicitation, not an actual proposal, and CMS states in the final rule that while it intends to make MVPs mandatory going forward, that "future date has not been determined and will be established through the official notice and comment rulemaking process."

For more information about MVP option, including registering for the MVP in 2024, please click here.

- **Complex Organization Adjustment:** CMS is finalizing a complex organization adjustment to account for the organizational complexities facing APM Entities (including Shared Savings Program ACOs) and virtual groups when reporting eCQMs. Under this proposal, CMS 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 may not exceed 10% of the total available measure achievement points in the quality performance category.

- **Performance Category Weighting in Final Score:** CMS is finalizing maintaining the same performance category weights as they were in 2024. The weights are required by law.

  General Performance Category Weights Proposed for 2025:
  - Quality: 30%
  - Cost: 30%
  - Promoting Interoperability (EHR): 25%
  - Improvement Activities: 15%

  CMS finalized its proposal to allow clinicians to request reweighting for quality, improvement activities, and/or Promoting Interoperability performance category(ies) where data are inaccessible and unable to be submitted due to reasons outside of the control of the clinician because the clinician delegated submission of the data to their third party intermediary (evidenced by a written agreement) and the third party intermediary didn't submit the data on the clinician's behalf in accordance with applicable deadlines.

- **Performance Threshold**: CMS will maintain their current performance threshold policies, keeping the performance threshold at 75 points.

- **Other MIPS Proposals:** CMS is finalizing the following proposals:
  - Maintain the 75 percent data completeness threshold through the 2028 performance period;
  - Decrease the inventory of quality measures from 198 to 195 through the addition of 7 and the removal of 10 MIPS quality measures (a net decrease of 3 quality measures);
    - Add 6 new episode-based cost measures and modify 2 existing cost measures (net 35);

        - Add 2 new improvement activities, modify 1 existing improvement activities, and remove 4 existing improvement activities for a total of 104 in the MIPS inventory; and
    - Apply a flat benchmarking methodology to a subset of topped out measures – those that belong to specialty sets with limited measure choice and a high proportion of topped out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.

- **Cost Measure Scoring:** CMS is finalizing its proposal to revise the cost scoring benchmarking methodology starting in 2024 performance period/2026 MIPS payment year. The cost scoring methodology uses a new distribution for cost scoring in which the median cost for a measure would be set at a score derived from the performance threshold established for that MIPS payment year. For example, for the CY 2024 performance period/2026 MIPS payment year, the median would be set at 7.5, the performance threshold equivalent. The cut-offs for benchmark point ranges will then be calculated based on standard deviations from the median.