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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 July 10, 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).

Comments on the proposed rule are due in 60 days on September 9, 2024. The final rule is expected to be released on or around November 1, 2024—with an effective date of January 1, 2025.

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

Physician Fee Schedule

- **Conversion Factor:** Over the last several years, there have been a series of Congressional fixes to help offset a significant budget neutrality adjustment, as required by law. This requirement under the Medicare PFS forces CMS to make an overarching negative adjustment to physician payments to counterbalance any increases in code values that CMS implements. CMS usually does this by adjusting the Medicare "conversion factor" (CF) which converts the building blocks of PFS codes (relative value units or RVUs) into a dollar amount. Congress has been able to offset the majority of the budget neutrality cut that was expected go into place in 2021, 2022, 2023, and 2024. With respect to 2024, Congress provided a total of 2.93% in relief through the Consolidated Appropriations Act of 2023 (CAA, 2023) and the CAA, 2024. Since the relief that was provided in 2024 only lasts for one year and CMS is stuck with its current statutory limitations, the agency has to cut at least that amount from the 2025 CF.

  Budget Neutrality Adjustments and Total Conversion Factor Reduction

  In addition to that 2.93 percent cut, CMS made other adjustments to code values and added new codes. All these modifications lead to a .05 percent positive budget neutrality adjustment.

  The proposed CY 2025 PFS conversion factor reflects the statutory 2.93% cut and the 0.05 percent budget neutrality adjustment—and is $32.3562, a decrease of $0.93 or -2.8% percent from the CY 2024 PFS conversion factor of $33.2875. Emergency medicine reimbursement in 2025 would remain flat, not including the 2.9 percent Congressional fix.

Conversion factors	CY 2024 CF	CY 2025 CF	Difference	Percent Cut
Proposed 2024 CF	33.2875	32.3562	-0.9313	-2.797

- **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 proposing 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**

  Emergency Department (ED) Evaluation and Management (E/M) Codes: In previous PFS rules, CMS has examined which of the codes that are temporarily on the list of approved Medicare telehealth services during the COVID-19 public health emergency (PHE) would remain on the list for an extended period or permanently.

  Most recently, in the CY 2024 rule, CMS created a new "provisional category" along with a permanent category and established criteria for codes to be added to each category. If added to the provisional category, CMS did not specify how long it could remain there before being removed. CMS added all five ED E/M code levels 1-5 (CPT codes 99281-99285), the critical care codes, and the observation codes on the approved telehealth list through at least December 31, 2024.

  In this year's rule, CMS does not propose any changes to current provisional codes, effectively keeping these ED codes on the provisional list for at least one more year.

  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 proposing to adopt the 17 new telemedicine E/M services.

  Other telehealth provisions 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.

  CMS does not have any other telehealth policies in part because the waivers have not yet been extended by Congress after the end of 2025.

- **Behavioral Health Services:** CMS is proposing 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 is proposing 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. Additionally, CMS is proposing 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 is soliciting feedback about capacity and workforce issues in relation to acute care and is seeking comment on when it may be appropriate to receive care in an urgent care clinic rather than an ED. Specifically, CMS asks the following questions:

    - What types of services would alternative settings to EDs need to offer to meet beneficiaries' non-emergent, urgent care needs?
    - Does the current "Urgent Care Facility" Place of Service code (POS 20) adequately identify and define the scope of services furnished in such settings? Is this place of service code sufficiently distinct from others such as "Walk-in Retail Health Clinic (POS 17) and "Office" (POS 11)? If not, how might these Place of Service code definitions be modified?
    - Does the existing code set accurately describe and value services personally performed by professionals and costs incurred by the facility in these settings?
    - How might potential strategies to reduce overcrowding and wait times in EDs advance equity in access to health care services?

- **Opioid Treatment Programs:** CMS is proposing 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 proposing to allow 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 proposing payment increases in response to recent regulatory reforms for OUD treatment finalized by SAMHSA at 42 CFR part 8. Specifically, CMS is proposing to update 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 proposing 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 HCPCS add-on 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. In the rule, CMS is proposing, among other proposals, to 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:** In last year's rule, CMS finalized expanded payment for dental services. In this year's rule, CMS is proposing 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 also proposing 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 introduces 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 (formally Meaningful Use). 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 2024.***

  In this year's rule, CMS is proposing to add 1 quality measure and remove 2 quality measures from the Emergency Medicine MVP. CMS is also proposing to add 1 improvement activity, remove 1 improvement activity, and remove the weights associated with the improvement activities contained in this MVP.

  CMS is also proposing 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 not previously laid out a specific timeline for making this transition, in this year's rule, CMS issues a RFI seeking comments on clinician readiness to transition to MVPs with the additional sunset of traditional MIPS (which has a target sunset data of 2029), considerations on the availability and applicability of MVPs for all clinicians, and establishing subgroup composition criteria. **Though the target sunset date for traditional MIPS is 2029, CMS is NOT proposing it at this time.**

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

- **Complex Organization Adjustment:** CMS is proposing 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 proposing to maintain 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%

  However, CMS is proposing 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 proposes to maintain their current performance threshold policies, keeping the performance threshold at 75 points.

- **Other MIPS Proposals:** CMS is proposing to:
  - Maintain the 75 percent data completeness threshold through the 2028 performance period;
  - Decrease the inventory of quality measures from 198 to 196 through the addition of 9 and the removal of 11 MIPS quality measures (a net decrease of 2 quality measures);
    - Add 6 new episode-based cost measures and modify 2 existing cost measures (net 35);
    - Add 2 new improvement activities, modify 2 existing improvement activities, and remove 8 existing improvement activities for a total of 100 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 proposing to revise the cost scoring benchmarking methodology starting in 2024 performance period/2026 MIPS payment year. The proposed cost scoring methodology would use 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 would then be calculated based on standard deviations from the median.