Summary of the CY 2025 Medicare Physician Fee Schedule Final Rule

On November 1, 2024, the Centers for Medicare and Medicaid Services (CMS) released the CY 2025 Medicare Physician Fee Schedule (MPFS) final rule. This regulation also impacts the Quality Payment Program (QPP). CMS released accompanying fact sheets on the for the MPFS and Medicare Shared Savings Program. The provisions in the final rule will take effect on January 1, 2025, except where otherwise specified. The AAFP provided comprehensive comments on the proposed regulation.

Finalized Provision	AAFP Analysis	AAFP Recommendations
Conversion Factor & Estimated Impact on Family Medicine		
The 2025 conversion factor is $32.35, a decrease of $0.94 (or 2.83%) from the current CY 2024 conversion factor of $33.29.	Negative	The AAFP has continuously raised significant concerns with recent year-over-year conversion factor reductions and the increasing inadequacy of Medicare payment rates. We're calling on Congress to stop these annual payment reductions.
CMS estimates that total allowed charges for family physicians would not be impacted by policies contained in the rule, however CMS does not include the reduction to the conversion factor attributable to expiration of temporary congressional funding in its analysis.	Negative	The AAFP estimates that the aggregate impact for most family physicians will approximate the conversion factor reduction. Without congressional funding for the conversion factor, the changes that would otherwise have a favorable impact on family medicine will be negated.
CMS will continue to update clinical labor pricing as part of its practice expense relative value unit methodology in CY 2025.	Positive	The AAFP supports CMS' plan to further update clinical labor pricing, which will help ensure Medicare physician payment rates more appropriately account for the costs of hiring and retaining clinical staff.
Evaluation and Management (E/M) Visits		
The G2211 add-on code for visit complexity will be payable when reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare	Positive	The AAFP has strongly advocated for the G2211 add-on code to be payable when modifier 25 is appended to the accompanying office/outpatient

Part B preventive service, including the Initial Preventive Physical Examination (IPPE), furnished in the office or outpatient setting. CMS also clarified that G2211 will be payable when billed alongside the annual wellness visit (AWV) as it is a preventive service.		E/M). G2211 is an incremental but meaningful step toward recognizing the complexity and value of comprehensive, longitudinal primary care.
Advanced Primary Care Management		
CMS is establishing coding and payment under the PFS for a new set of APCM services described by three new HCPCS G-codes (G0556, G0557, G0558). The finalized APCM services incorporate elements of several existing care management and communication technology-based services into a bundle of services that reflects the essential elements of the delivery of advanced primary care, including Principal Care Management, Transitional Care Management, and Chronic Care Management. However, unlike existing care management codes, there are no time-based thresholds included in the service elements, which is intended to reduce the administrative burden associated with current coding and billing.	Positive	The AAFP supported the creation of these new codes as an important step toward achieving hybrid primary care payment outside of a demonstration or pilot.
The new APCM codes are stratified into three levels based on an individual's number of chronic conditions and status as a Qualified Medicare Beneficiary, reflecting the patient's medical and social complexity: • Level 1 (G0556) is for persons with one chronic condition; • Level 2 (G0557) is for persons with two or more chronic conditions; and • Level 3 (G0558) is for persons with two or more chronic conditions and status as a Qualified Medicare Beneficiary.	Positive	The AAFP was strongly supportive of CMS' decision to establish APCM codes and descriptors that reflect all elements of service furnished during a month without specifying the amount of time that must be spent furnishing the services during the month and without including time-related billing restrictions for the elements of the services. This allows the billing physician to report APCM services for a beneficiary even if the beneficiary has no interaction with that physician or their auxiliary personnel during the month if the practice can provide all APCM elements.
The valuation of the final APCM codes was increased slightly from the proposed amount: • Level 1 (G0556)	Positive	The AAFP advocated for an increased valuation for APCM codes. We will continue to monitor the valuation of these codes as they are implemented.

○ Work RVU: 0.25 ○ Approximate national rate: $15 • Level 2 (G0557) ○ Work RVU: 0.77 ○ Approximate national rate: $50 • Level 3 (G0558) ○ Work RVU: 1.67 ○ Approximate national rate: $110 CMS also indicated a willingness to revisit valuation of APCM codes in the future.		
Telehealth		
CMS is finalizing as proposed the policy to allow two-way, real-time audio-only for any telehealth service furnished to a beneficiary in their home when the patient is not capable of or does not consent to use of video technology.	Positive	The AAFP supported this proposal.
Through CY 2025, CMS will continue to permit distant site practitioners to use their currently enrolled practice locations instead of their home addresses when providing telehealth services from their home.	Positive	The AAFP supported this proposal.
CMS is finalizing a policy to continue to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only in clinical instances when the service is furnished virtually (for example, a three-way telehealth visit, with the patient, resident, and teaching physician in separate locations) through December 31, 2025.	Positive	The AAFP supported this proposal but also urged the agency to allow a teaching physician to have a virtual presence, regardless of whether the service is provided in-person or via telehealth, alongside several other organizations. The agency said they would consider the clinical instances when PFS payment is appropriate for teaching physicians furnishing services that involve residents in future rulemaking.
Through CY 2025, CMS will continue to define “direct supervision” as permitting the presence and immediate availability	Positive	The AAFP supported this proposal but also urged the agency to make permanent a physician’s ability

of a supervising physician to include the use of real-time audio-video telecommunications technology for a subset of services.		to directly supervise non-physician clinicians via real-time audio-video telecommunications technology for all services.
Behavioral Health		
CMS is creating separate coding and payment for safety planning interventions. HCPCS code G0560 will be billable as a standalone code, rather than an add-on code as proposed. It may also be billed in units of 20 Minutes. • *HCPCS code G0560: Safety planning interventions, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health professionals or agencies; and making the environment safe; (List separately in addition to an E/M visit or psychotherapy).*	Positive	The AAFP advocated in support of this code and specifically asked CMS to modify its proposal to allow it to be furnished as a stand-alone service billable in 20 minute increments , rather than as an add-on code.
CMS is creating a monthly billing code to describe the specific protocols involved in furnished in 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. • *HCPCS code G0544: Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, per calendar month.*	Positive	The AAFP supported the creation of this code and successfully advocated for CMS to allow for consent for such services to be obtained from the patient during the initial phone call.
CMS adopted three codes, G0552-G0554, for digital mental health treatment devices furnished under a behavioral health treatment plan of care.	Neutral	The AAFP was neutral on this proposal.

Certification of Therapy Plans of Care with a Physician or NPP Order		
For physical or occupational therapy and speech language pathology services, CMS will accept a physician's or NPP's signed and dated order as equivalent to a signature on the initial certification of a therapist-established plan of treatment in cases where the 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.	Positive	The AAFP supported this proposal as a policy which will eliminate duplicative documentation requirements placed on physicians who have already issued an order or referral for therapy.
Rural Health Clinics and Federally Qualified Health Centers		
CMS finalized a new payment policy for General Care Management Services, which unbundles code G0511 and allows clinics to bill instead by individual HCPCS codes.	Positive	The AAFP supported this proposal.
As part of CMS finalizing new codes for APCM services, the agency finalized a proposal to allow RHCs to bill APCM codes alongside physicians paid under traditional fee-for-service.	Positive	The AAFP supported this proposal.
CMS finalized a proposal to allow RHCs and FQHCs to bill for all four Part B preventive vaccines and their administration at the time of service, beginning July 1, 2025.	Positive	The AAFP strongly supported this proposal.
Through CY 2025, CMS will continue to define "immediate availability" in FQHCs and RHCs to include real-time, interactive audio/visual communications for the direct supervision of services provided incident to a physician's service.	Positive	The AAFP supported this proposal.
Through CY 2025, CMS will continue to allow payment to RHCs and FQHCs for medical visit services furnished via telecommunications technology.	Positive	The AAFP supported this proposal.

Through CY 2025, CMS will continue to delay the in-person visit requirement for mental health services furnished via communication technology by RHCs and FQHCs to patients in their homes.	Positive	The AAFP supported this proposal.
Medicare Shared Savings Program		
CMS finalized a proposal for a new "prepaid shared savings" program for ACOs in BASIC track Levels C-E or the ENHANCED track with a history of generating savings within the Shared Savings Program (SSP). Eligible ACOs that choose to participate will receive quarterly advanced payments based on prior shared savings. Advanced payments must be used to enhance staffing, infrastructure, or offer additional services to beneficiaries and at least 50 percent of the payments must be allocated to beneficiary services not otherwise covered by Medicare such as meals, transportation, dental care, vision care, or reductions in Part B cost sharing. ACOs that fail to earn shared savings must reimburse CMS. To participate, an ACO must submit a supplemental application during the annual MSSP application cycle, with payments starting the next performance year. ACOs that renewed or entered an agreement beginning on January 1, 2025, may elect to participate in 2026 without renewing again.	Positive	The AAFP supported this proposal but encouraged CMS to provide more flexibility in how payments are used.
ACOs entering a new agreement starting January 1, 2025, will be subject to a Health Equity Benchmark Adjustment (HEBA) that provides an upward adjustment to historical benchmarks if 15 percent or more of their assigned beneficiaries are either enrolled in the Medicare Part D low-income subsidy (LIS) or dually eligible for both Medicare and Medicaid.	Positive	The AAFP supported this proposal.
CMS will implement a new Alternative Payment Pathway (APP) Plus quality measure set that aligns with Adult Universal Foundation measures. CMS modified the timeline to allow SSP ACOs more time to become familiar with the additional measures. SSP ACOs must report the APP Plus measure set as electronic	Negative	The AAFP strongly opposed the requirement for MSSPs to report the APP Plus measures set. AAFP also advocated for CMS to maintain the MIPS CQM reporting option for the foreseeable future but is

quality measures (eCQMs), Medicare CQMs, or a combination. CMS will allow ACOs to report the measure set using MIPS CQMs in performance years 2025 and 2026 only.		encouraged by CMS' decision to allow more time before sunsetting MIPS CQMs.
CMS will no longer terminate participation agreements with ACOs that fail to maintain a minimum of 5,000 assigned beneficiaries. Starting in 2025, ACOs that fall short of the beneficiary requirement may remain in the program and work to increase their beneficiary count until the time they seek to renew their agreement. ACOs will still be required to meet the required 5,000 beneficiary minimum to renew for a new agreement period.	Positive	The AAFP supported this more flexible approach to eligibility requirements which will reduce the risk of involuntary termination in the Shared Savings Program (SSP) due to temporary fluctuations in an SSP ACO's beneficiary count.
CMS modified the definition of "primary care services" used for the purpose of assigning Medicare FFS beneficiaries to ACOs. CMS also expanded exceptions to the program's voluntary alignment policy — a beneficiary may still be assigned to another entity in CMS Innovation Center model if the beneficiary has claims related to services or treatments targeted by the model, or when the Secretary determines assignment is necessary to test the model. Beneficiaries may still identify a primary clinician from a SSP ACO as their main health care provider, but this designation alone does not guarantee their assignment.	Neutral	The AAFP suggested excluding interprofessional consultation codes except 99452, which CMS accepted. CMS declined to exclude caregiver training service codes (97750-97752) as the AAFP suggested. The AAFP did not support the proposal to allow additional exceptions to the voluntary assignment policy
Starting in January 2025, ACOs will no longer have to provide Beneficiary Notification follow-up communications with beneficiaries prior to their next primary care service. Instead, ACOs are required to provide this follow up within 180 days of the original notification.	Positive	The AAFP supported these changes as they will reduce administrative burden on ACOs.
Medicare Part B Payment for Preventive Services		
CMS expanded the list of groups at risk of contracting hepatitis B to include any individual without a complete hepatitis vaccine series or with unknown vaccine history. In 2025, hepatitis B	Positive	The AAFP supported this proposal as it would allow family physicians to receive payment for hepatitis B vaccines and their administration for a larger group of beneficiaries (Previously, Part B coverage was

vaccines and their administration are covered under Part B for a larger group of beneficiaries.		limited to individuals with specific risk factors associated with contracting hepatitis B).
CMS updated and expanded coverage for colorectal cancer (CRC) screening to include a follow-on screening colonoscopy after a biomarker test as well as computed tomography colonography. CMS removed barium enema procedures from CRC screening coverage.	Positive	The AAFP supported this proposal which will allow family physicians to offer the most appropriate CRC screening modality based on an individual's risk factors and preferences.
Quality Payment Program		
CMS will maintain the performance threshold of 75 points for the 2025 performance year/2027 payment year. MIPS eligible clinicians must meet or exceed the performance threshold to avoid a MIPS negative payment adjustment of up to 9 percent.	Positive	The AAFP supported this proposal.
CMS finalized six new MVPs: • Complete Ophthalmologic Care, • Dermatological Care, • Gastroenterology Care, • Optimal Care for Patients with Urologic Conditions, • Pulmonology Care, and • Surgical Care.	Neutral	The AAFP was neutral on the new MVPs but urged the agency to consider how the comprehensive nature of primary care makes condition specific MVPs less applicable to primary care physicians.
CMS will maintain the data completeness threshold of at least 75 percent for the CY2027 and CY2028 performance periods. This threshold would apply to QCDR measures, MIPS CQMs, eCQMs, Medicare Part B claims, and Medicare CQMs.	Neutral	The AAFP expressed concern with the data completeness threshold as it is currently too high.
CMS finalized the addition of six episode-based cost measures beginning in 2025: • Chronic Kidney Disease, • End-Stage Renal Disease, • Kidney Transplant Management, • Prostate Cancer, • Rheumatoid Arthritis, and	Neutral	The AAFP was neutral on these new measures but encouraged the agency to reconsider how cost is measured as existing cost measures are not designed to capture the long-term cost savings and may penalize near-term investments in comprehensive care.

• Respiratory Infection Hospitalization		
CMS finalized the creation of the APP Plus quality measure set that will incorporate additional Universal Foundation measures. The APP Plus measure set is optional for eligible clinicians, groups, subgroups, and virtual groups participating in MIPS APMs. It is required for SSP ACOs.	Neutral	The AAFP supports CMS' efforts to align quality measures across programs but expressed concerns with specific measures included in the Universal Foundation.
CMS finalized its proposal to modify the scoring of the improvement activities category. Activities will no longer be weighted. Instead, eligible clinicians in small or rural practices, health professional shortage areas, or those reporting via MIPS Value Pathways (MVPs) will need to report one activity. All other eligible clinicians must report two activities.	Positive	The AAFP supported CMS' efforts to simplify scoring.
CMS finalized its proposal to revise the cost scoring benchmarking methodology, starting with the 2024 performance period. The new methodology addresses concerns that eligible clinicians with costs near the median often receive disproportionately low scores.	Neutral	The AAFP appreciates CMS' efforts to address concerns related to the cost category scoring. However, the AAFP reiterated overarching concerns with the cost category and asked CMS to apply the updated methodology retroactively or reweight the cost category to zero.