Summary of the CY 2025 Medicare Physician Fee Schedule Proposed Rule

On Wednesday July 10, the Centers for Medicare & Medicaid Services (CMS) released the CY 2025 Medicare Physician Fee Schedule (MPFS) proposed rule. This regulation also impacts the Quality Payment Program (QPP). CMS also released accompanying fact sheets on the MPFS and Medicare Shared Savings Program proposals. Comments on the proposed rule are due by September 9, 2024. The AAFP will thoroughly review the proposed rule and provide comments to CMS. The final rule will be released around November 1, 2024, and will take effect on January 1, 2025, except where specified otherwise in the final rule.

2024 Conversion Factor and Overall Impact on Family Medicine

CMS proposes to decrease the conversion factor (i.e., the amount Medicare pays per relative value unit (RVU)) to $32.35, a decrease of 2.8%, from CY 2024. This is due to expiring conversion factor relief enacted by Congress and budget neutrality adjustments. When considering expiring conversion factor relief, the AAFP estimates the impact will be a 1.9% decrease in total allowed charges for family physicians.

While all providers paid under the fee schedule are subject to the payment decrease attributable to the reduced conversion factor, the impact to family physicians is less severe than the average due to a number of proposals included in the rule that will benefit family practice. CMS touts the 2025 proposed rule as an important step to advance whole-person care, noting its proposal to establish a new, advanced primary care management bundle, expanded access to behavioral, preventive, and oral health services as well as a number of updates to the Medicare Shared Saving Program and the Quality Payment Program, as discussed below.

Determination of Practice Expense RVUs

CMS proposes multiple, technical refinements to its PE RVU methodology and the pricing of specific supply and equipment items and supply packs. CY 2025 is the final year of CMS's four-year transition to updated clinical labor pricing. CMS did not receive new wage data or other additional information for use in clinical labor pricing from interested parties before the publication of this proposed rule. Therefore, CMS's proposed clinical labor pricing for CY 2025 is based on the clinical labor pricing CMS finalized in the CY 2024 PFS final rule, incremented an additional step for the final Year 4 of the update.

CMS is not proposing to incorporate the 2017-based Medicare Economic Index (MEI) in PFS rate setting for CY 2025. As it did for 2024, CMS is delaying any application of the rebased and revised MEI pending the results of the AMA's practice cost data collection efforts and other sources of data CMS could consider for updating the MEI. CMS invites comments on this approach. CMS also solicits comments on:

- The general topic of more comprehensive updates to supply and equipment pricing.

- Ways CMS may continue work to improve the stability and predictability of any future updates, particularly regarding scheduled, recurring updates to PE inputs for supply and equipment costs.

Payment for Telehealth Services Under Section 1834(m) of the Social Security Act

CMS intends to conduct a comprehensive analysis of all codes on the Medicare Telehealth Services list before determining which codes should added on a permanent basis.

CMS is proposing to remove the frequency limitations for Subsequent Inpatient Visits (CPT codes 99231-99233), Subsequent Nursing Facility Visits (CPT codes 99307-99310), and Critical Care Consultation Services (HCPCS codes G0508 and G0509) for CY 2025. CMS will gather additional data to determine how practice patterns are evolving and what permanent changes, if any, should be made to frequency limitations.

CMS proposes to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home through CY 2025. They are also proposing to temporarily extend the amended definition of "direct supervision" to permit the virtual presence of the physician through audio/video real-time communications technology through CY 2025. CMS proposes to permanently permit virtual direct supervision for a subset of services, while other services would only permit virtual direct supervision through Dec. 31, 2025.

CMS is proposing to allow two-way, real-time audio-only for any telehealth service furnished to a patient in their home when the patient is not capable of or does not consent to use of video technology. However, once the PHE-related telehealth flexibilities expire on December 31, 2024, the patient's home is only a permissible originating site for mental health and substance use disorder-related services, as well as for monthly ESRD-related clinical assessments.

CMS proposes to extend its virtual presence policy for teaching physicians billing for services involving residents through CY 2025. The teaching physician's virtual presence requires real-time observation (not just availability) and excludes audio-only technology.

CMS included a request for information on a permanent expansion of the list of services under the primary care exception, a change AAFP requested. The primary care exception allows teaching physicians to bill for services furnished by residents when certain conditions are met.

Valuation of Specific Codes

CMS addresses proposed values for work and practice expense for multiple specific codes. Among those of interest to family medicine are:

- Therapeutic Apheresis and Photopheresis (CPT codes 36514, 36516, and 36522)
- Telemedicine Evaluation and Management (E/M) Services (CPT codes 9X075, 9X076, 9X077, 9X078, 9X079, 9X080, 9X081, 9X082, 9X083, 9X084, 9X085, 9X086, 9X087, 9X088, 9X089, 9X090, and 9X091)
- COVID Immunization Administration (CPT code 90480)
- Acupuncture - Electroacupuncture (CPT codes 97810, 97811, 97813, and 97814)
- Annual Alcohol Screening (HCPCS codes G0442 and G0443)
- Annual Depression Screening (HCPCS code G0444)
- Behavioral Counseling & Therapy (HCPCS codes G0445, G0446, and G0447)

- Preexposure Prophylaxis (PrEP) of Human Immunodeficiency Virus (HIV) (HCPCS codes G0011, G0012, and G0013)

Additionally, CMS makes a series of proposals related to payment for caregiver training services. These include proposals on:

- How to bill for assessing the caregiver's skills and knowledge for the purposes of caregiver training services.
- New coding and payment for caregiver training for direct care services and supports and individual behavior management/ modification caregiver training services.

Lastly, CMS makes a request for information (RFI) on services addressing health-related social needs. This is a broad RFI on the newly (2024) implemented Community Health Integration (HPCCS codes G0019, G0022), Principal Illness Navigation (HCPCS codes G0023, G0024), Principal Illness Navigation- Peer Support (HCPCS codes G0140, G0146), and Social Determinants of Health Risk Assessment (HCPCS code G0136) services to engage interested parties on additional policy refinements for CMS to consider in future rulemaking.

Evaluation and Management (E/M) Visits

CMS is proposing to reduce restrictions on the add-on code (G2211) for office visits in certain instances. In previous years, the add-on code was not payable for claims when modifier 25 was accompanying the office/outpatient evaluation and management (E/M) code. However, in direct response to AAFP's advocacy, beginning in 2025 the add-on code will be payable when modifier 25 is used to indicate the following services were furnished at the same encounter as the E/M service:

- Medicare Annual Wellness Visit (AWV),
- vaccine administration, or
- any Medicare Part B preventive services.

Enhanced Care Management

CMS proposes new bundled payments for advanced primary care teams and notes this is a first step in a multiyear effort toward hybrid payment and accountable care. CMS is creating three new HCPCS codes for advanced primary care management (APCM) services that incorporate elements of several existing care management and communication technology-based services into a bundle. Practices must meet several requirements before billing the codes that CMS describes as consistent with services routinely adopted by practices participating in advanced primary care models.

CMS proposes that APCM services would be stratified into three levels based on certain patient characteristics that are indicative of patient complexity and the consequent resource intensity involved in the provision of APCM services:

- Level 1 [GPCM1]: Patients with one or fewer chronic conditions.
- Level 2 [GPCM2]: Patients with two or more chronic conditions.
- Level 3 [GPCM3]: Patients with two or more chronic conditions and who are Qualified Medicare Beneficiaries.

The new APCM services can be provided once per service period (month) and only by a single practitioner who assumes the care management role with a particular beneficiary.

Unlike the existing care management service codes, e.g., chronic care management and transitional care management, the APCM services will not include time thresholds in the code descriptors. CMS recognizes that ongoing care management and coordination services are standard parts of advanced primary care, even in months when documented clinical staff or billing professional minutes may not reach the required thresholds for billing or the patient's condition does not meet the clinical thresholds for care management services under the existing code set.

CMS is proposing that not all elements included in the APCM code descriptors must be furnished during any given calendar month for which the service is billed. However, even if all elements are not provided each month, a practice must still be able to furnish every service element. They anticipate that all APCM scope of service elements would be routinely provided, as deemed appropriate for each patient, acknowledging that not all elements may be necessary for every patient during each month.

CMS has released an RFI to gather feedback on potential hybrid payment policies to create new sustainable pathways to support advanced primary care, equitable access to high-quality primary care, and continued transformation among a wide variety of practices. CMS seeks feedback on a broad set of questions related to care delivery and incentive structure alignment, and five foundational components (streamlined value-based care opportunities; billing requirements; person-centered care; health equity, clinical and social risk; and quality improvement and accountability).

CMS proposes a new code for an annual cardiovascular risk assessment administered on the same day as an E/M visit, based on a risk-reduction model tested during the CMS Innovation Center's Million Hearts Cardiovascular Disease (CVD) Risk Reduction model.

Certification of Therapy Plans of Care with a Physician Order

CMS proposes to amend the process by which therapy plans of care are certified by creating an exception to the requirement that physicians or qualified health professional sign the plan of care when a written order or referral is on file and the therapist has documented evidence that the plan of care has been transmitted to the physician within 30 days. CMS also seeks comment on whether this exception should include a time limit on when a physician can modify the plan of care and how recent an order must be in order to qualify for the exception.

Advancing Access to Behavioral Health Services

CMS also proposes to expand behavioral health services by creating a Safety Planning Intervention add-on-G-code to be billed along with an E/M visit or psychotherapy service and a monthly billing code supportive of Safety Planning Interventions that is a bundled service for specific protocols of post-discharge follow-up contacts in conjunction with discharge from an emergency department for a crisis encounter.

CMS also proposes to permanently allow opioid treatment programs (OTP) to provide audio-only visits for periodic assessments, in addition to allowing audio-visual visits for the initiation of treatment with methadone.

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

CMS proposes requiring RHCs and FQHCs to bill the individual HCPCS codes that comprise general care management HCPCS code G0511 and to use the same codes as are billed under

the PFS. Subsequently, the agency proposes removing the requirement for RHCs and FQHCs to report HCPCS code G0511. Payment rates would be updated annually based on total PFS amounts and would be paid at the national non-facility PFS payment rate. CMS proposes to continue permitting billing add-on codes related to these services and to adopt the coding and policies of Advanced Primary Care Management (APCM) services.

CMS proposes to continue allowing payment for non-behavioral health care visits delivered via telecommunications technology through December 31, 2025. The agency proposes to continue delaying the in-person visit requirement for patients regarding mental health care services currently provided via telehealth by RHCs and FQHCs until January 1, 2026.

CMS proposes allowing RHCs and FQHCs to bill for Part B preventive vaccines at the time they are administered. This change would allow FQHCs to receive payment for immunizations much earlier, before annual cost reconciliation reports.

CMS proposes removing RHC productivity standards, given the restructured payment limits for RHCs that were passed in the Consolidated Appropriations Act, 2021 (CAA, 2021). For FQHCs, the agency proposes a rebased, productivity-adjusted market basket update of 3.5 percent.

CMS proposes to amend the Provision of Services Conditions for Certification and Conditions of Coverage to add standards that would explicitly require RHCs and FQHCs to furnish primary care services, as well as explicitly prohibit RHCs from being a rehabilitation facility or a facility primarily dedicated to behavioral health care. Under this proposal, previous CMS interpretive guidance stating RHCs must be "primarily engaged in furnishing primary care services" – calculated by whether 50 percent of an RHC's hours are spent providing primary care services – would no longer be enforced. These proposed changes are meant to clarify the intent and requirements of the program governing RHCs and FQHCs and are designed to allow RHCs to provide more outpatient specialty services (as appropriate in a clinician's scope of practice) and better meet the needs of patient populations. CMS considers primary care practice "the entry point into the health care system" and quoted the AAFP's definition of primary care practice in this proposal. The agency seeks public comment on what types of behavioral health care RHCs offer, how often those services are being provided, and what barriers RHCs face in providing behavioral health care.

Clinical Laboratory Fee Schedule

In accordance with current law, CMS proposes to make conforming changes to the regulatory data reporting and payment requirements related to tests under Medicare's clinical laboratory fee schedule (CLFS). CMS proposes to revise the definitions of both the "data collection period" and "data reporting period" to specify that for the data reporting period of January 1, 2025, through March 31, 2025, the data collection period is January 1, 2019, through June 30, 2019. CMS also proposes to revise its regulations to indicate that initially, data reporting begins January 1, 2017, and is required every 3 years beginning January 2025.

Additionally, CMS proposes conforming changes to its requirements for the phase-in of payment reductions to reflect current law. Specifically, CMS proposes to revise its regulations to indicate that for CY 2024, payment may not be reduced by more than 0.0 percent as compared to the amount established for CY 2023, and for CYs 2025 through 2027, payment may not be reduced by more than 15 percent as compared to the amount established for the preceding year.

Medicare Shared Savings Program

CMS proposes to make several changes refining Shared Savings Program policies which are directionally consistent with the AAFP's advocacy to improve value-based care participation opportunities for family physicians, particularly those caring for underserved populations. CMS has also published a request for information seeking comments on financial arrangements that could allow for higher risk and potential reward than are available under the current ENHANCED track within the Shared Savings Program.

Prepaid Shared Savings

CMS is proposing a new program called "prepaid shared savings" for Accountable Care Organizations (ACOs) that are part of the BASIC track's Levels C-E or participating in the ENHANCED track with a proven record of generating shared savings within the Medicare Shared Savings Program (MSSP). Qualifying ACOs will receive quarterly advanced payments based on their previously earned shared savings. These funds are intended to be invested in enhancing staffing levels, healthcare infrastructure, and offering additional services to beneficiaries. At least 50 percent of these prepaid shared savings must be allocated to direct beneficiary services that fall outside the scope of traditional Medicare coverage. This includes essential services such as meals, transportation, dental care, vision care, hearing aids, and reductions in Part B cost-sharing.

ACOs are obligated to repay the advanced payments from their future earned shared savings. Should the shared savings prove insufficient, the ACOs will be held accountable for reimbursing CMS directly. CMS has crafted this proposal with the intention of maintaining a budget-neutral framework.

ACOs interested in participating in this program will need to submit supplemental information during the annual MSSP application cycle, with the program set to begin on January 1, 2026.

Health Equity Benchmark Adjustment

In an effort to promote equity, CMS proposes a Health Equity Benchmark Adjustment (HEBA) for ACOs entering new agreement periods starting January 1, 2025. The proposed HEBA would be calculated based on the percentage of an ACO's assigned beneficiaries who are either enrolled in the Medicare Part D low-income subsidy (LIS) program or are dually eligible for both Medicare and Medicaid. By introducing HEBA, CMS is offering a new avenue for ACOs to receive an upward adjustment to their historical benchmarks. Under this proposal, an ACO's historical benchmark could be adjusted upwards using the highest value among three possible adjustments: a positive regional adjustment, a prior savings adjustment, or the HEBA.

This change is particularly aimed at benefiting ACOs that serve a larger portion of beneficiaries from underserved communities, especially those that may have received lower regional adjustments or prior savings adjustments in the past, or none at all.

CMS proposes that ACOs with less than 20% of their assigned beneficiaries enrolled in the Medicare Part D LIS or are dually eligible would not be eligible for this adjustment. According to CMS's projections, if this proposal were to be implemented, approximately 20 out of 456 ACOs in 2023 would qualify for a HEBA that exceeds any prior savings or regional adjustments. On average, these ACOs could expect an increase of $230 per capita, which translates to an average increase of 1.57% to their historical benchmarks.

Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set, Scoring Methodology, and Incentives to Report via electronic Clinical Quality Measures (eCQMs)

CMS proposes to implement a new Alternative Payment Pathway (APP) quality measure set that would include the six measures currently in the set and incrementally incorporate the remaining five Adult Universal Foundation measures by the 2028 performance year. CMS proposes that MSSP ACOs would be required to report the APP Plus measure set as electronic clinical quality measures (eCQMs), Medicare CQMs, or a combination. MIPS CQMs and the CMS Web Interface will no longer be available.

Eligibility Requirements and Application Procedures

Currently, ACOs are held to a standard of maintaining a minimum of 5,000 assigned beneficiaries throughout their agreement period in the Shared Savings Program. Failure to meet this threshold could lead to termination from the program. CMS is proposing a shift in policy to take effect on January 1, 2025. With this change, ACOs would still need to meet the 5,000-beneficiary requirement to initiate a new agreement period, but should they fall short during the agreement period, they would be granted until the time of renewal to regain compliance. This offers a reprieve, allowing ACOs to remain in the program and work towards increasing their beneficiary count.

Beneficiary Assignment Methodology

Beginning January 1, 2025, CMS plans to redefine what constitutes “primary care services” for the purpose of assigning Medicare FFS beneficiaries to ACOs. This redefinition aims to align with the payment policy proposals under the Medicare Physician Fee Schedule (PFS). The proposed expansion includes a variety of services such as Safety Planning Interventions, Post-Discharge Telephonic Follow-up Contacts, Virtual Check-in Services, Advanced Primary Care Management Services, Cardiovascular Risk Assessment and Risk Management, Interprofessional Consultation, and Caregiver Training Services in both direct care and behavior management/modification.

CMS is also proposing an expansion of a previously established exception within the Shared Savings Program’s voluntary alignment policy. This policy change is in response to the development of disease-specific models by the CMS Innovation Center, which utilize claims for both primary care and other types of services to assign beneficiaries to participating entities. Under the proposed changes, beneficiaries would retain the freedom to voluntarily identify a primary clinician from a Shared Savings Program ACO as their usual source of care. However, this designation alone would not automatically result in their assignment to a Shared Savings Program ACO.

To put this into perspective, for Performance Year (PY) 2024, there are roughly 152,000 beneficiaries who have selected a primary clinician that is a Shared Savings Program ACO clinician. Out of these, approximately 83,000 beneficiaries are voluntarily aligned to a Shared Savings Program ACO, having met all the necessary assignment eligibility criteria. Yet, this number constitutes a relatively small fraction of the overall Shared Savings Program assigned beneficiary population, which stands at about 10.8 million beneficiaries. A simulation using PY 2024 data reveals that less than 1 percent (703 beneficiaries) who are currently voluntarily aligned to a Shared Savings Program ACO would be reassigned based on claims to an entity participating in a CMS Innovation Center model.

Beneficiary Notification Requirements

CMS is proposing changes to the Beneficiary Notification follow-up requirements within the Shared Savings Program to take effect January 1, 2025. Under the current system, ACOs must provide follow-up communication to beneficiaries no later than either their next primary care service visit or within 180 days of the initial written notice. However, ACOs have reported challenges with this requirement, particularly when the next primary care visit is scheduled shortly after the original notification, or when the timing of such visits is unpredictable. Responding to these concerns, CMS is proposing to eliminate the need for follow-up communication to coincide with the next primary care visit. Instead, ACOs would only be required to provide this follow-up within 180 days of the original notification.

Furthermore, for ACOs operating under preliminary prospective assignment with retrospective reconciliation, CMS is looking to narrow the scope of beneficiaries who must receive notifications. The proposal suggests focusing on those beneficiaries who are more likely to be assigned to the ACO, such as those who have received at least one primary care service from an ACO professional during the assignment window.

Medicare Part B Payment for Preventive Services

CMS is proposing to expand eligibility criteria for coverage of the hepatitis B vaccine under Part B (based on updated research about hepatitis B risk). This proposed change would eliminate existing requirements for a physician order to receive the hepatitis B vaccine and allow mass immunizers to use roster billing. CMS further proposes hepatitis B immunizations administered in FQHC/RHC settings to follow the same payment methodology as other Part B vaccines, which CMS is further proposing should be paid when administered as opposed to annual cost reconciliation reports.

Updates to the Quality Payment Program

CMS continues to refine MIPS by making a series of proposals including six new Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) related to ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care, as well as revisions to two existing measures. CMS also proposes to revise its cost measure scoring methodology to assess a clinician's costs more appropriately in relation to national averages, and to streamline scoring in the improvement activities performance category by eliminating activity weighting.

CMS proposes to maintain the current performance of 75 points and the data completeness criteria of 75 percent.

CMS issued several requests for information for input on:

- MVP adoption and subgroup participation,
- ways to improve public health reporting through the Public Health and Clinical Data Exchange Objective in promoting interoperability category,
- establishing principles for patient-reported outcome measures in federal models and quality reporting and payment programs, and
- the potential expansion of the survey modes for the Consumer Assessment of Healthcare Providers and Suppliers for MIPS survey.