



Policy Update

CMS Finalizes CY 2025 Physician Fee Schedule

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2025 Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Medicare Part B [CMS-1807-F] Final Rule, which includes policies related to Medicare physician payment and the Quality Payment Program (QPP). Physicians and other clinicians once again face large cuts; the cut for CY 2025 is 2.83%. The rule outlines the limitations of the current fee schedule structure, and while Congress has provided temporary partial fixes to physician payment in recent years, the relief expires at the end of 2024 unless legislation is passed.

In addition to the payment cuts, CMS finalized significant policies related to telemedicine, changes to the Merit-Based Incentive Payment System (MIPS) cost and improvement activity scoring, movement towards the MIPS Value Pathways (MVPs), and several other important policies.

Key takeaways from the CY 2025 PFS Final Rule:

- **Conversion Factor (CF) Reduction:** CMS finalized a 2025 CF of \$32.3465, a reduction of more than 2.83% from the 2024 physician CF of \$33.2875, and a 2025 anesthesia CF of \$20.3178, representing a 2.20% reduction from the 2024 anesthesia CF of \$20.7739.
- **Add-On Code for Complexity:** CMS finalized its proposal to expand the add-on code for complexity, G2211, by allowing it to be billed when the underlying evaluation and management (E/M) service is performed on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.
- **Telehealth:** CMS maintains that it has limited statutory authority to extend most Medicare telehealth policies. Without congressional action, the major Medicare telehealth waivers will expire on December 31, 2024, and return to pre-COVID-19-public-health-emergency (PHE) policies.
- **Merit-Based Incentive Payment System:** CMS will maintain the MIPS performance threshold at 75 points but signaled efforts to move reporting towards the MVPs by 2029.
- **Medicare Shared Savings Program (MSSP):** CMS established a new prepaid shared savings option, created a health equity benchmark adjustment to encourage participation, aligned quality measure reporting with the Universal Foundation quality measures, and made adjustments to account for the impact of certain improper payments in program financial calculations.
- **Health Equity:** CMS finalized an add-on payment for conducting ongoing social determinants of health (SDOH) risk assessments, allowing initial visits for treatment with methadone to be provided virtually, and allowing audio-only periodic assessments. The rule also finalizes standalone G codes and payment for safety planning interventions and follow-up services post-discharge for a crisis encounter.

Read on for a topline summary of the major provisions in the final rule.



- Final rule [text](#)
- CMS [press release](#)
- CMS [fact sheet](#)
- CMS [fact sheet](#) on the MSSP
- CMS [fact sheet](#) on the QPP
- CMS [fact sheet](#) on the Medicare Prescription Drug Inflation Rebate Program

Our interactive **dashboard** shows proposed Medicare fee-for-service payment rates for 2025 at the national and local level for services paid under the Medicare PFS. You can use this information to look at trends in national payment rates over the last five years and identify how service level payments differ across localities.



PFS Major Payment Policies

Conversion Factor

Medicare physician payment is based on the application of a dollar-based CF to geographically adjusted work, practice expense (PE), and malpractice relative value units (RVUs). Work RVUs capture the time, intensity, and risk of the provider. PE RVUs capture the cost of supplies, equipment, and clinical personnel wages used to furnish a specific service. Malpractice RVUs capture the cost of malpractice insurance.

Key Takeaway: The finalized CY 2025 CF is \$32.3465, a 2.83% decrease from CY 2024.

Medicare Physician Conversion Factor (2017 – 2025)		
Year	CF	Actual Update (%)
Jan 1, 2017	35.8887	0.24
Jan 1, 2018	35.9996	0.31
Jan 1, 2019	36.0391	0.11
Jan 1, 2020	36.0896	0.14
Jan 1, 2021	34.8931	-3.32
Jan 1, 2022	34.6062	-0.82
Jan 1, 2023	33.8872	-2.08
Jan 1, 2024	33.2875	-1.77
Jan 1, 2025	32.3465	-2.83

The final CY 2025 CF is **\$32.3465**. This represents a 2.83% decrease from the 2024 CF of \$33.2875. The final CY 2025 anesthesia CF is **\$20.3178**. This represents a **2.20%** decrease from the 2024 anesthesia CF of \$20.7739. The CF update is primarily based on three factors:

1. A statutory 0% update for CY 2025¹.
2. A 0.02% positive budget neutrality adjustment.
3. A funding patch passed by Congress that expires at the end of 2024.

The CY 2025 payment reductions show the continued impact of no inflationary update imbedded in the current PFS. They also come at a time when physician practices, hospitals that employ physicians, and other stakeholders are facing rising costs due to inflation, staffing shortages, and significant challenges posed by other regulatory burdens (e.g., prior authorization, interoperability requirements, and participation in

Medicare quality programs such as MIPS). In light of these burdens, the provider community likely will continue to press Congress for relief, although it is unclear if lawmakers are willing to fully offset the payment reductions or seek broader reforms later this year or in 2025.

Specialty Impact

Key Takeaway: Specialty impacts range from -2% to +4%.

Actual payment rates are affected by a range of finalized policy changes related to physician work, PE, and malpractice RVUs. CMS summarized the aggregate impact of these changes in Table 110 in the final rule. Additional details on the facility/non-facility payment impact by specialty are summarized in Table 111. While the impact on individual practices will vary based on service mix, Tables 110 and 111 provide insight into the overall impact of the final rule’s policies for a specific specialty. Specialty impacts range

¹ The [Medicare Access and CHIP Reauthorization Act of 2015](#) established a 0% update for PFS services through 2025. Beginning in 2026, clinicians identified as qualified participants in an Advanced Alternative Payment Model will receive an annual 0.75% update, and all other clinicians will receive a 0.25% annual update.



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from -2% for diagnostic testing facility, interventional radiology, ophthalmology, and vascular surgery, to +2% for anesthesiology, +3% for clinical psychologist, and +4% for clinical social worker. Specialty impacts are generally related to finalized RVU changes for specific services, the fourth year of the clinical labor pricing update, and/or the finalized adjustments to transfer of postoperative care for global surgical procedures.

Impact of Final Changes by Selected Specialties

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of Malpractice RVU Changes	Combined Impact
Anesthesiology	\$1,591	1%	1%	0%	2%
Clinical Psychologist	\$737	3%	1%	0%	3%
Clinical Social Worker	\$854	3%	1%	0%	4%
Diagnostic Testing Facility	\$942	0%	-2%	0%	-2%
Interventional Radiology	\$445	0%	-2%	0%	-2%
Ophthalmology	\$4,667	-1%	-1%	0%	-2%
Vascular Surgery	\$998	0%	-2%	0%	-2%

Note: Combined impact may not equal the sum of work, PE, and malpractice because of rounding. Source: Table 110, CY 2025 final rule, display copy.

90-Day Global Surgery Payment Accuracy

Key Takeaway: CMS finalized its proposal, with modification, to require the use of transfer of care modifier -54 (and associated payment reduction) for all 90-day global surgical packages where a practitioner expects to furnish only a portion of a global package.

Global packages are single codes that are valued to include all services provided during a specified period (zero days, 10 days, or 90 days) by a physician or another practitioner in the same group practice for a specific surgical procedure. The global package includes:

- The surgical procedure itself.
- Post-operative E/M visits and discharge services.
- Pre-operative visits on the day of and/or prior to the surgical procedure.
- Other services during the post-operative period that are related to the surgical procedure.

For several years now, CMS and other agencies such as the Office of Inspector General for the US Department of Health and Human Services have raised concerns about the accuracy of valuation and payment for global packages under the PFS. CMS has longstanding concerns that global packages are valued based on inaccurate estimates of the number and type of services actually furnished during the specified number of global days. In CY 2015, CMS finalized a policy to transition all 10- and 90-day global packages to zero-day global packages, which would allow any post-operative visits furnished after the day of the surgical procedure to be billed separately as standalone visits. However, CMS was prohibited from implementing this finalized policy because of an amendment in the Medicare Access and CHIP Reauthorization Act (MACRA). The MACRA amendment also required CMS to collect data, beginning in 2017, on the number and level of post-operative visits typically provided to patients during 10- and 90-day global periods, and to use this new data and other data, beginning in 2019, to improve the accuracy of



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global package valuation. In the nine years since, CMS has initiated research contracts and implemented data collection processes related to this mandate, and [released multiple reports](#) on the number of E/M visits furnished during post-operative periods and potential approaches to revalue global packages. In CY 2023, CMS solicited comments on strategies for revaluing and appropriately paying for these services.

For CY 2025, CMS proposed to revise the transfer of care policy for global packages to address instances where one practitioner furnishes the surgical procedure and another practitioner who is not in the same group furnishes related post-operative E/M visits during the global period. CMS also proposed to develop a new add-on code that would account for the resources involved in the post-operative care provided by a practitioner who did not furnish the surgical procedure. CMS stated that this proposed policy would be a “first step toward improved valuation and payment” while retaining the fundamental payment structure of the global packages, and would provide more accurate information on the resources involved in furnishing components of the global packages.

Under current PFS policy, transfer of care modifiers must be appended to the relevant global package code when billing for services that are within the scope of the global package only when the proceduralist and one or more other practitioners who are not in the same group as the proceduralist formally document their agreement to provide distinct portions of the global package.² Based on an analysis of Medicare fee-for-service claims data, CMS stated that these formal transfer of care modifiers are rarely used, and when they are, it is often with respect to certain ophthalmologic procedures (for example, cataract surgery). The transfer of care modifiers include:

- **Modifier -54 Surgical Care Only:** indicates that the proceduralist performed only the surgical procedure portion of the global package.
- **Modifier -55 Post-Operative Management Only:** indicates that the practitioner performed only the post-operative management portion of the global package.
- **Modifier -56 Pre-Operative Management Only:** indicates that the practitioner performed only the pre-operative portion of the global package.

CMS finalized the proposal to broaden applicability of transfer of care modifier -54, beginning with services furnished in CY 2025, for all 90-day global packages in any case where a practitioner plans to furnish only a portion of a global package, including when there is a formal, documented transfer of care, as under current policy, or an informal, non-documented but expected transfer of care. In response to public comments, CMS did not finalize the proposal to similarly broaden the applicability of transfer of care modifiers -55 and -56. Instead, CMS will maintain the current policy that modifiers -55 and -56 should be billed exclusively in cases where there is a documented, formal transfer of care.

CMS finalized the proposal to adjust payment for the entire global package if a transfer of care modifier is included on the claim, as under the current policy. As discussed in the “Regulatory Impact Analysis” section of the final rule, CMS expects that modifier -54 will be employed 20% of the time for a relatively small set of high-volume and/or high-cost 90-day codes. For these cases, CMS will apply the same payment reduction associated with modifier -54 as under current policy. The estimated spending reduction associated with the transfer of care modifier policy is redistributed across the PFS via a positive budget neutrality adjustment to the CF for CY 2025.

² CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 11287.



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In addition to the finalized transfer of care policy, CMS finalized a new HCPCS code, G0559³, to capture the additional practitioner time and resources spent in providing follow-up post-operative care by a practitioner who did not perform the surgical procedure. CMS expects that G0559 will be billed once during the 90-day post-operative period by the physician or other practitioner who did not perform the surgery (and who is not in the same group) but who is seeing the patient for an office/outpatient E/M visit that is related to the recent surgical procedure. CMS finalized G0559 with modification such that it may be billed by a practitioner *of the same specialty* as the proceduralist who is not in the same group practice as the proceduralist. CMS reaffirmed that G0559 should not be billed by another practitioner in the same group practice as the practitioner who performed the surgical procedure, even if the other practitioner is of a different specialty. The rationale for this is that when a patient is seen by practitioners in the same group practice regardless of their specialty, the same resources are not incurred during post-operative care compared to when a patient is seen by a practitioner who is not in the same group practice.

For CY 2025, CMS finalized a work RVU of 0.16 for G0559, as proposed, which represents approximately one half of the assigned work RVU for CPT code 90785⁴ and similarly has no direct PE inputs. CMS estimates utilization of approximately 40,000 total claims in the first year for G0559 and noted that this utilization estimate has only a “relatively small” impact on budget neutrality.

Finally, CMS acknowledged that historically, the CPT Editorial Panel has created CPT codes to describe services for which CMS originally established G-codes and adopted them through the CPT Editorial Panel process. CMS stated that it will consider using any newly available CPT coding to describe services similar to those described by G0559 in future rulemaking.

Modification to the New Add-On Code for Complexity

Key Takeaway: CMS will allow the add-on code for complexity, G2211, to be billed when the office/outpatient E/M base code is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

In the CY 2024 PFS final rule, CMS finalized a new office/outpatient E/M visit complexity add-on code, G2211. CMS established requirements for when G2211 could be billed, including restricting its use when the underlying office/outpatient E/M visit is reported with modifier -25, which denotes a significant, separately identifiable office/outpatient E/M visit by the same physician or other qualified healthcare professional on the same day as a procedure or other service.

Some commenters expressed concern about this restriction because some preventive services such as the annual wellness visit (AWV) or a preventive vaccine are often provided on the same day as a separately identifiable office/outpatient E/M visit, billed with modifier -25. After considering these concerns, CMS will allow payment of G2211 when the office/outpatient E/M base code is reported by the same practitioner on the same day as an AWV, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. This policy will be effective in CY 2025.

³ G0559, Post-operative follow-up visit complexity inherent to E/M services addressing surgical procedure(s), provided by a physician or qualified healthcare professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable: ++ Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen because of the unique circumstances of the patient's operation. ++ Research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty). ++ Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately. ++ Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient E/M visit, new or established).

⁴ 90785, Interactive complexity (List separately in addition to the code for primary procedure)



Advanced Primary Care Management Services

Key Takeaway: CMS added new G-codes to reflect the growing adoption of the advanced primary care approach to care.

CMS finalized the addition of a new set of advanced primary care management (APCM) services described by three new HCPCS G-codes (G0556, G0557, and G0558). The 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. The new APCM codes are stratified into three levels based on the number of chronic conditions and enrollment as a qualified Medicare beneficiary, reflecting both patient medical and social complexity.

Both physicians and non-physician practitioners who use an advanced primary care model of care may bill for APCM services when they are the continuing focal point for all necessary healthcare services and responsible for all the patient’s primary care needs. Moreover, CMS added APCM services as designated care management services, which means they can be provided by auxiliary personnel under the general supervision of the billing practitioner. To bill for these services, practitioners must meet a performance measurement requirement, which can be satisfied by reporting the Value in Primary Care MVP.

HCPCS codes G0556, G0557, and G0558 may only be reported once per calendar month, and only by the single practitioner who assumes the care management role with a particular beneficiary for that time. CMS also prohibits concurrent billing by the same practitioner or another practitioner within the same practice for the same patient for the following services:

- Chronic Care Management CPT codes 99487, 99489, 99490, 99491, 99439, 99437
- Principal Care Management CPT codes 99424, 99425, 99426, 99427
- Transitional Care Management CPT codes 99495, 99496
- Interprofessional consultation CPT codes 99446, 99447, 99448, 99449, 99451, 99452
- Remote evaluation of patient videos/images HCPCS code G2250
- Virtual check-in HCPCS codes G2251, G2252
- E-visits CPT codes 98970, 98971, 98972, 99421, 99422, 99423

CMS acknowledged that commenters overwhelmingly supported the proposed coding and payment policies to recognize APCM services, particularly the simplified billing and documentation requirements and the shift away from time-based payment. CMS originally proposed an RVU of 0.17, or approximately \$10 per month, for Level 1 APCM services. CMS, however, increased the valuation to 0.25, or approximately \$15 per month, to better account for the work and PE in furnishing APCM services to this population.

Advanced Primary Care Management Coding and Payment

HCPCS	Description	Final CY 2025 Work RVU	Final CY 2025 Non-Facility Payment Rate
G0556	Level 1 APCM services for a patient with one or fewer chronic conditions	0.25	\$15
G0557	Level 2 APCM services for a patient with two or more chronic conditions	0.77	\$50



HCPSCS	Description	Final CY 2025 Work RVU	Final CY 2025 Non-Facility Payment Rate
G0558	Level 3 APCM services for a patient who is a qualified Medicare beneficiary with two or more chronic conditions	1.67	\$110

Source: Tables 17 and 27, CY 2025 final rule, display copy.

Advanced Primary Care Hybrid Payment Request for Information

Key Takeaway: CMS will continue to review feedback in response to the advanced primary care hybrid payment request for information (RFI).

In the CY 2025 PFS proposed rule, CMS noted that the APCM codes represent a drive toward accountable care and paying for primary care services with hybrid payments (a mix of encounter- and population-based payments) to support longitudinal relationships between primary care providers and beneficiaries. CMS included an RFI on advanced primary care hybrid payment, seeking additional input on future payment and coding practices, specifically streamlined value-based care opportunities; billing requirements; person-centered care; health equity, clinical, and social risk; and quality improvement and accountability. CMS plans to summarize comments received in response to this RFI in a separate publication, which it will make available on the PFS website.

Rebasing and Revising the Medicare Economic Index

Key Takeaway: CMS did not make any methodological or data source changes to the Medicare Economic Index (MEI) for CY 2025 in light of the American Medical Association’s (AMA’s) current data collection effort.

The MEI measures the input price pressures of providing physician services looking at physicians’ own time (compensation) and practice costs (PEs). While the MEI is no longer directly used in calculating the annual update to the CF, it continues to be used for the Medicare telehealth originating site facility fee, targeted medical review threshold amounts, rural health clinic payment limits, geographic practice cost index, and other policies. Current MEI weights reflect 2006 costs based on data for self-employed physicians from the 2007/2008 AMA Physician Practice Information Survey (PPIS).

In CY 2023, CMS finalized but delayed implementation of a proposal to rebase and revise the MEI to reflect more current market conditions and practice costs using publicly available data. Because the MEI changes would result in a substantial redistribution of PFS spending among specialties, CMS delayed implementation of this policy in CY 2023 and solicited comments on when and how to best incorporate these changes for future rulemaking. In CY 2024, CMS again delayed implementation of this policy to provide additional time to consider other data sources while the AMA’s data collection activities to update the PPIS were ongoing.

In the CY 2025 final rule, CMS stated that many commenters supported the agency’s continued delayed implementation of the 2017-based MEI. The AMA RVS Update Committee (RUC) informed CMS that it concluded the PPIS on August 31, 2024, and is working to analyze the data, which it will share with CMS. Some commenters requested a more frequent update of the PPIS (e.g., every three to five years) given the dramatic redistributive impacts of implementing updated data after many years. However, other commenters disagreed with more frequent PPIS updates because they can be burdensome, particularly for small, independent practices in underserved areas, given the significant time it takes to complete the survey. Other commenters urged CMS to consider contingencies or alternatives to the PPIS to address



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lack of data availability or response rates for some specialties. Another commenter requested that CMS seek alternative, more current data sources to rebase and revise the MEI if the AMA PPIS data proves insufficient. This commenter stated that the 2017-based MEI that CMS finalized in CY 2023 is derived predominantly from 2017 US Census Bureau data that is already outdated and should therefore not be used for updates.

Practice Expense Methodology

Key Takeaway: CMS did not make any changes to the PE methodology for CY 2025 but will continue to engage with stakeholders on potential future updates, including better ways to account for modern medical technologies and services such as software as a medical device and artificial intelligence.

PE is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages. CMS develops PE RVUs based on the direct and indirect practice resources involved in furnishing each service. Direct expenses include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expenses, and all other expenses.

In recent years, CMS has developed policies geared toward providing more consistent updates to the direct PE inputs, including supply/equipment pricing updates finalized in CY 2019 and clinical labor pricing updates finalized in CY 2022 (both phased in over four years). However, indirect PE data inputs are still based on legacy information primarily from the AMA PPIS, which reflects 2006 data. CMS believes that indirect PE data inputs, like direct PE data inputs, would benefit from a refresh that implements similar standard and routine updates to reduce the likelihood of unpredictable shifts in payment, especially when such shifts could be driven by the age of the underlying data rather than information about changes in actual costs. In CY 2023 and CY 2024 rulemaking, CMS issued general comment solicitations on ways to improve the collection of PE data inputs (including indirect PE inputs) and refine the PE methodology (including indirect PE allocation) for future rulemaking. Most commenters urged CMS to defer any significant changes until the updated AMA PPIS results become available.

In the CY 2025 final rule, many commenters expressed concerns about the current PE methodology, particularly its inadequacies in accommodating modern medical technologies and services, such as software as a medical device and artificial intelligence. These commenters stated that CMS should revise its PE methodology to better reflect the actual costs of running medical practices today, including more frequent updates and the incorporation of direct costs for software and innovative technologies. Many commenters also supported the AMA's ongoing PPIS to ensure updated and accurate data informs PE calculations. Commenters urged CMS to collaborate closely with medical associations and incorporate broad stakeholder feedback without increasing reporting burdens, particularly for smaller practices.

Supply Pack Pricing Update

Key Takeaway: CMS finalized the proposed supply pack pricing update, as recommended by the RUC, with modification.

Interested parties have identified numerous discrepancies between the aggregate cost of some supply packs and their individual item components and have urged CMS to rectify these errors. The AMA RUC convened a workgroup on this subject and submitted recommendations to update pricing for a series of supply packs along with the RUC's comment letter for the CY 2024 rule cycle. CMS did not address this issue in the CY 2024 proposed rule because of the significant projected cost revisions, but the agency did propose to implement the supply pack pricing update and other revisions recommended by the RUC for



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CY 2025.

CMS finalized the proposed supply pack pricing update for CY 2025, with modifications. Specifically, CMS finalized all the supply pack pricing changes as proposed for CY 2025 except for three supply packs for which CMS finalized a four-year pricing transition to minimize any potential disruptive effects that could be caused by other sudden shifts in RVUs because of the high number of services that use these common supply packs. The four-year phase-in is consistent with how CMS has phased in other PE changes with significant redistributive effects, including recent supply/equipment and clinical labor pricing updates.

Supply Pack with Pricing Transition

CMS Code	Description	# of Codes	2024 Price	New Price	Year 1 (CY 2025)	Year 2 (CY 2026)	Year 3 (CY 2027)	Final (CY 2028)
SA042	pack, cleaning and disinfecting, endoscope	306	\$19.43	\$31.29	\$22.40	\$25.36	\$28.33	\$31.29
SA058	pack, urology cystoscopy visit	38	\$113.70	\$37.63	\$94.68	\$75.67	\$56.65	\$37.63
SA082	pack, ophthalmology visit (w-dilation)	145	\$3.91	\$2.33	\$3.52	\$3.12	\$2.73	\$2.33

Source: Table 5, CY 2025 final rule, display copy.

Commenters requested that CMS update prices for an additional 15 supply packs for which the sum of the individual components does not match the price of the corresponding pack. However, CMS did not finalize pricing updates for these additional 15 supply packs because of reservations about potential pricing disruptions. CMS noted that 10 of these supply packs are included in the direct PE inputs for at least 100 codes, and three of the packs are included in more than 1,000 codes. Many of these pricing updates would lead to drastic changes in pricing, which could lead to significant shifts in the overall PE RVU for the affected codes. CMS anticipates returning to this subject in future rulemaking.

Supply Pack Pricing Requested by Commenters

# of Codes	Item Name	CMS Code	Current Price	New Price	% Change
111	pack, basic injection	SA041	\$10.45	\$17.28	65%
560	pack, cleaning, surgical instruments	SA043	\$12.61	\$11.09	-12%
3	pack, moderate sedation	SA044	\$18.55	\$19.20	4%
4,568	pack, minimum multi-specialty visit	SA048	\$5.02	\$1.98	-61%
168	pack, ophthalmology visit (no dilation)	SA050	\$2.72	\$1.35	-50%
239	pack, pelvic exam	SA051	\$20.16	\$2.81	-86%
1,079	pack, post-op incision care (staple)	SA052	\$4.80	\$9.90	106%
469	pack, post-op incision care (suture & staple)	SA053	\$5.47	\$11.54	111%
1,708	pack, post-op incision care (suture)	SA054	\$4.62	\$10.34	124%
12	pack, post-op incision care, craniotomy	SA055	\$7.30	\$18.18	149%



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# of Codes	Item Name	CMS Code	Current Price	New Price	% Change
24	pack, post-op incision care, neurosurgical	SA056	\$6.20	\$16.05	159%
120	pack, drapes, ortho, large	SA080	\$37.30	\$25.38	-32%
29	pack, drapes, ortho, small	SA081	\$2.25	\$1.88	-16%
119	pack, protective, ortho, large	SA083	\$10.86	\$14.75	36%
27	pack, protective, ortho, small	SA084	\$5.99	\$8.15	36%

Source: Table 6, CY 2025 final rule, display copy.

Clinical Labor Pricing Update

Key Takeaway: CMS finalized the final year of the clinical labor pricing update without refinements.

Beginning in CY 2019, CMS updated the supply and equipment prices used for PE as part of a market-based pricing transition. Updated supply and equipment prices were phased in over four years. Beginning in CY 2022, and in conjunction with the final year of the supply and equipment pricing update, CMS updated the clinical labor prices used for PE based on US Bureau of Labor Statistics data and other supplementary sources. Updated clinical labor prices were similarly phased in over four years. CY 2025 is the final year of this four-year transition.

CMS did not receive new wage data or other additional information for use in clinical labor pricing from interested parties prior to the publication of the CY 2025 proposed rule. CMS therefore proposed to continue using the clinical labor pricing that the agency finalized in the CY 2024 final rule for CY 2025, incremented for year four of the update. CMS did not receive new wage data during the public comment period and therefore finalized clinical labor prices as proposed without refinement for CY 2025.

Example of Clinical Labor Pricing Transition

Current Price	\$1.00	
Final Price	\$2.00	
Year 1 (CY 2022) Price	\$1.25	1/4 difference between \$1.00 and \$2.00
Year 2 (CY 2023) Price	\$1.50	1/3 difference between \$1.25 and \$2.00
Year 3 (CY 2024) Price	\$1.75	1/2 difference between \$1.50 and \$2.00
Final (CY 2025) Price	\$2.00	

Source: Table 7, CY 2025 final rule, display copy.

Potentially Misvalued Codes

Key Takeaway: CMS finalized its proposal to nominate four posterior osteotomies codes as potentially misvalued.

The Affordable Care Act mandates regular review of fee schedule rates for physician services paid by Medicare, including services that have experienced high growth rates. CMS established the potentially misvalued code process to meet this mandate. Codes that are identified for review under this process



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may eventually have their values increased, decreased, or maintained. For CY 2025, CMS received five nominations concerning various codes.

For CY 2025, CMS finalized its proposal to nominate CPT codes 22210, 22212, 22214, and 22216 as potentially misvalued. The AMA RUC supported the proposal to nominate these codes, which were last reviewed in 1995, as potentially misvalued.

Access to Behavioral Health and Related Services

Services Addressing Social Determinants of Health and Opioid Treatment Programs

Key Takeaway: CMS finalized coding and payment for conducting ongoing SDOH risk assessments, allowing initial visits for treatment with methadone to be provided virtually, and allowing audio-only periodic assessments.

CMS finalized its proposal to permanently allow opioid treatment programs to furnish periodic assessments via audio-only telecommunications beginning January 1, 2025, as long as all applicable requirements are met and use of the technologies is permitted under the applicable Substance Abuse and Mental Health Services Administration and US Drug Enforcement Administration requirements at the time the services are furnished. CMS reiterated that “in cases where a beneficiary does not have access to two-way audio-video communications technology, periodic assessments can be furnished using audio-only telephone calls if all other applicable requirements are met.”

CMS also finalized its proposal to allow the opioid treatment program intake add-on HCPCS code G2076 to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone. CMS codified that services to initiate treatment with methadone may be furnished via two-way interactive audio-video communication technology.

Lastly, CMS finalized its proposal to update the payment rate for intake activities and the payment rate for periodic assessments by adding the value of the non-facility rate for SDOH risk assessments HCPCS code G0136. CMS did not initially consider various circumstances that may prevent an opioid treatment program from being able to perform SDOH risk assessments at intake (e.g., patients being under the influence) and was persuaded that multiple SDOH risk assessments may be necessary and should have related payment updates.

Safety Interventions and Post-Discharge Follow-Up

Key Takeaway: CMS finalized coding and payment for safety planning interventions and follow-up services post-discharge for a crisis encounter.

Safety planning interventions involve a patient working with a clinician to develop a personalized list of coping and response strategies and sources of support that the person can use if they have thoughts of harming themselves or others. This is not a suicide risk assessment, but rather an intervention provided to people determined to have elevated risk.

CMS finalized its proposal to create separate coding and payment for safety planning interventions and a monthly billing code to describe the specific protocols involved in furnishing post-discharge follow-up contacts, with modifications. In response to public comment, CMS finalized the creation of HCPCS code G0560 as a standalone code rather than an add-on code as proposed, and will allow billing in units of 20 minutes rather than only allowing one 20-minute code. CMS finalized that, for CY 2025, HCPCS code G0560 must be personally performed by the billing practitioner in a variety of settings, but the agency



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stated that it will continue to consider this issue for further rulemaking. HCPCS code G0560 will also be added to the Medicare telehealth list.

CMS finalized the creation of a monthly billing code, HCPCS code G0544, to describe the specific protocols involved in furnishing follow-up contacts after a discharge from the emergency department for a crisis encounter as a bundled service. HCPCS code G0544 describes four calls in a month, each lasting between 10 and 20 minutes. It can be billed by practitioners, including auxiliary personnel, in any instance in which the beneficiary has been discharged following a crisis encounter, including discharge from psychiatric inpatient care, or crisis stabilization. The billing practitioner must meet a threshold of at least one real-time telephone interaction with the patient to bill the code, and unsuccessful attempts to reach the patient will not qualify as a real-time telephone interaction.

Digital Mental Health Treatment

Key Takeaway: CMS finalized coding and payment for some digital mental health treatment (DMHT) devices.

For CY 2025, CMS finalized Medicare payment to billing practitioners for DMHT devices cleared by the US Food and Drug Administration (FDA) under Section 510(k) of the Food, Drug, and Cosmetic Act or granted *de novo* authorization by FDA. Such DMHT devices must be classified under 21 CFR 882.5801 for mental or behavioral health treatment, and must be furnished incident to professional behavioral health services used in conjunction with ongoing behavioral health treatment under a behavioral health treatment plan of care. CMS finalized three new HCPCS codes to report these services.

Digital Mental Health Treatment Services Coding and Payment

HCPCS	Description	Final CY 2025 Work RVU	Non-Facility Payment Rate
G0552	Supply of DMHT device and initial education and onboarding	Contractor priced	Contractor priced
G0553	First 20 minutes of monthly treatment management for use of DMHT device	0.62	\$21
G0554	Each additional 20 minutes of monthly treatment management	0.61	\$20

Source: Table 17, CY 2025 final rule, display copy.

While some stakeholders requested that CMS adopt national pricing, CMS declined to do so in the final rule. Instead, the supply code (G0552) will be contractor priced by each of the Medicare Administrative Contractors (MACs). Contractor pricing for HCPCS code G0552 doesn't mean that the service will not be covered or paid by Medicare, but rather that each MAC will determine the payment amount.

Billing for Interprofessional Consultations

Key Takeaway: CMS finalized the addition of codes and expansion of the types of practitioners eligible to bill for interprofessional consultations.

CMS finalized six new codes to allow clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors to bill for interprofessional consultations with other practitioners



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whose covered services are limited by statute and with physicians and practitioners who can bill Medicare for E/M services and would use the current CPT codes to bill for interpersonal consultations. The new HCPCS codes are:

- G0546, Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review.
- G0547, Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11 – 20 minutes of medical consultative discussion and review.
- G0548, Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21 – 30 minutes of medical consultative discussion and review.
- G0549, Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review.
- G0550, Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, five minutes or more of medical consultative time.
- G0551, Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes.

CMS finalized its proposal to value the new interprofessional consultation codes based on a crosswalk to the six CPT codes for interprofessional consultations for practitioners who can independently bill Medicare for E/M visits (CPT codes 99451, 99452, 99446, 99447, 99448, 99449), with refined work RVUs and no direct PE inputs.

Caregiver Training Services

Key Takeaway: CMS finalized coding and payment for three new caregiver training services and added these and other caregiver training services to the telehealth list on a provisional basis.

CMS finalized three new codes for direct care services and supports:

- G0541, Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the



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patient present), face-to-face; initial 30 minutes.

- G0542, Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use G0542 in conjunction with G0541).
- G0543, Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers.

CMS finalized valuation for the new caregiver training services as proposed. CMS also finalized its proposal to add these new caregiver training services, as well as existing caregiver training services, (CPT codes 97550, 97551, 97552, 96202, and 96203, and HCPCS codes G0541 – G0543 and G0539 – G0540) to the Medicare telehealth list on a provisional basis for CY 2025.

Telehealth and Other Remote Services

The Consolidated Appropriations Act (CAA), 2023, extended certain Medicare telehealth flexibilities related to the COVID-19 PHE through December 31, 2024. These waivers include flexibility related to where telehealth can be provided (e.g., at home), which services can be provided (e.g., expanded list of covered services), and the level of payment for these services (e.g., allowing the higher non-facility rate for office-based physicians).

In CY 2024 rulemaking and in the proposed CY 2025 rule, CMS warned of its statutory limitations to carry many of these flexibilities beyond December 31, 2024, and the impact that a temporary or permanent lapse would have on coverage and reimbursement for telehealth services. In the final CY 2025 rule, CMS repeated this sentiment and explicitly stated that absent congressional action, the statutory limitations that were in place prior to the pandemic will return. Such a return would mean the statutory restrictions on geography, site of service, and practitioner type that existed prior to the COVID-19 PHE would go back into effect. After the expiration of the PHE-related telehealth flexibilities on December 31, 2024, the patient's home will be a permissible originating site *only* for services for the diagnosis, evaluation, or treatment of a mental health or substance use disorder, and for the monthly end-stage renal disease (ESRD) related clinical assessments.

CMS finalized several policies that are not dependent on further action by Congress, such as virtual components of direct supervision and teaching physicians, as well as the updated definition of “interactive telecommunication.” It also made changes to its proposals on codes to be added to the Medicare telehealth list.

New CPT Codes to Report Telemedicine Evaluation and Management Services

Key Takeaway: CMS finalized its proposal to not reimburse the 16 new audio-visual and audio-only telemedicine E/M codes created by the CPT Editorial Panel. CMS also finalized its proposal to reimburse the new virtual check-in code.

In February 2023, the AMA CPT Editorial Panel approved a request to establish 16 new Category I E/M telemedicine codes for both new and established patients using audio-video or audio-only technology (CPT codes 98000 – 98015). The panel created eight codes for synchronous audio-video services, eight codes for synchronous audio-only services, and one code for an asynchronous virtual check-in service. The audio-video and audio-only code family subsets have parallel codes for new patients and established



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patients. Like other E/M codes, these codes may be reported based on the level of medical decision making or total time on the date of the encounter. For each set of four codes, there is a code that may be reported for a straightforward, low, moderate, and high level of medical decision making.

For CY 2025, CMS will not reimburse the 16 new audio-video and audio-only telemedicine E/M codes. Instead, CMS finalized its proposal to assign these codes a status indicator “I,” meaning that there is a more specific code that should be used for the purposes of Medicare. In this case, that code is one of the existing office/outpatient E/M codes (99201 – 99205 and 99211 – 99215) currently on the Medicare telehealth services list when billed with the appropriate place of service code to identify the location of the beneficiary and, when applicable, the appropriate modifier to identify the service as being furnished via audio-only communication technology.

CMS finalized its proposal to pay for the new virtual check-in code, CPT code 98016⁵, based on the RUC recommended work RVU of 0.30. 98016 is intended to replace that code. 98016 does not require the use of audio or video technology and is expected to be a patient-initiated service.

Updates to the Telehealth Services List

Key Takeaway: CMS finalized changes to the provisional and permanent lists and plans to conduct a comprehensive analysis of the codes currently on the provisional list.

CMS plans to move forward with its comprehensive analysis of all provisional codes currently on the Medicare telehealth services list before determining which codes should be made permanent or removed from the list. The agency did not provide any further clarity on a timeframe or steps for this review. CMS did not move any codes from provisional to permanent. The agency did, however, reverse course on several requests to add codes to the lists (see Table 11 in the final rule):

- **Continuous Glucose Monitoring:** CMS did not move ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report (CPT code 95251), to the permanent list, citing unmet criteria.
- **Cardiovascular and Pulmonary Rehabilitation:** CMS did not move cardiovascular rehabilitation services (CPT codes 93797 and 93798) and pulmonary rehabilitation services (CPT codes 94625 and 94626) to the permanent list, citing the agency’s plan to conduct a comprehensive analysis of the codes currently on the provisional list.
- **Health and Wellbeing Coaching:** CMS did not move health and wellbeing coaching (CPT codes 0591T – 0593T) to the permanent list, citing the agency’s plan to conduct a comprehensive analysis of the codes currently on the provisional list.
- **Psychological Testing and Developmental Testing:** CMS did not move psychological testing and developmental testing (CPT codes 96112, 96113, 96130, 96136, and 96137) to the permanent list, citing the agency’s plan to conduct a comprehensive analysis of the codes currently on the provisional list.
- **Therapy/Audiology/Speech Language Pathology:** CMS did not move therapy services (CPT codes 97110, 97112, 97116, 97161 – 97164, 97530, 97535, and 97165 – 97168) and audiology and speech language pathology services (CPT codes 92507, 92508, 92521 – 92524, 92526, 92607 – 92610, 96105, 92626, 92627, 96125, 97129, 97130, 92607 – 92609, 92550 – 92557, 92563, 92565, 92567, 92568, 92570, 92587, 92588, 92601 – 92604, 92625 – 92627, 92651 and

⁵ 98016, Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified healthcare professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment, five to 10 minutes of medical discussion.



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92652) to the permanent list, citing the agency’s plan to conduct a comprehensive analysis of the codes currently on the provisional list.

- **Care Management:** CMS did not add general behavioral health integration (CPT code 99484) and principal care management (CPT codes 99424 – 99427) to the provisional or permanent list.
- **Posterior Tibial Nerve Stimulation for Voiding Dysfunction:** CMS did not add posterior tibial neurostimulation (CPT code 64566) to the provisional or permanent list.
- **Radiation Treatment Management:** CMS retained radiation treatment management (CPT code 77427) on the provisional list.
 - This was a change from the proposed rule, in which CMS proposed to remove this code from the list altogether. CMS cited evidence from commenters that led the agency to reverse its decision and retain the code on the provisional list.
- **Home International Normalized Ratio (INR) Monitoring:** CMS did not add home INR monitoring (HCPCS code G0248) to the provisional list.
 - This was a change from the proposed rule, in which CMS proposed to add this service to the provisional list. CMS cited the need for additional time to work with stakeholders on future rulemaking.
- **Caregiver Training:** CMS added CPT codes 97550, 97551, 97552, 96202, and 96203, and HCPCS codes GCTD1-3 and GCTB1-2, to the provisional list for CY 2025.
- **Preexposure Prophylaxis of Human Immunodeficiency Virus:** CMS added HCPCS codes G0011 and G0013 to the permanent list.

Table 12 in the final rule provides a summary of the additions to the Medicare telehealth services list.

Other Changes to Codes

Key Takeaway: CMS finalized the continuation of temporary changes to frequency limitations.

During the PHE and through rulemaking for CY 2024, CMS suspended frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services. CMS finalized its proposal to again suspend the frequency limitations for CY 2025. The agency expects to gather an additional year of data to determine how practice patterns are evolving and what changes to frequency limitations, if any, should be made permanent.

Definition of Interactive Telecommunications System

Key Takeaway: CMS finalized updates to the definition of “interactive telecommunication system” to include any telehealth service.

CMS finalized an updated definition of “interactive telecommunications system” in the CY 2022 final rule. That definition allows for audio-only services under certain circumstances and permits the use of audio-only equipment for telehealth services furnished to established patients in their homes for purposes of diagnosis, evaluation, or treatment of mental health disorders (including substance use disorders) if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined previously, but the patient is not capable of, or does not consent to, the use of video technology.

For CY 2025, CMS finalized its proposal to expand this definition to include *any* telehealth service, not just diagnosis, evaluation, or treatment of mental health disorders. The agency clarified that two-way, real-time audio-only communication technology for telehealth services furnished at originating sites other than



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the patient's home is not permitted. The agency also finalized a proposed modifier to be appended to the claim for these services to verify that the specified conditions have been met: CPT modifier -93 and, for rural health clinics (RHCs) and federally qualified health centers (FQHCs), Medicare modifier -FQ (*Medicare telehealth service was furnished using audio-only communication technology*). Practitioners have the option to use modifier -FQ or -93, or both, where appropriate.

CMS reminds stakeholders that under current statute, as of January 1, 2025 (after the expiration of the PHE-related telehealth flexibilities on December 31, 2024), the patient's home is a permissible originating site *only* for services for the diagnosis, evaluation, or treatment of a mental health or substance use disorder, and for monthly clinical assessments related to ESRD.

Provider Home Address

Key Takeaway: CMS extended flexibilities related to a provider's home address through 2025.

CMS will continue to permit distant site practitioners to use their currently enrolled practice location address (instead of their home address) on Medicare enrollment forms when providing telehealth services from their home through CY 2025. The agency noted the importance of ensuring providers' safety and privacy as well as the shift in practice patterns toward telehealth, which made it appropriate to continue this flexibility for another year.

Direct Supervision

Key Takeaway: CMS finalized the continuation of some temporary flexibilities and permanency for certain services valued under the PFS.

During the COVID-19 PHE and for CY 2024, CMS allowed direct supervision to include virtual presence through audio/video real-time communications technology. Instead of requiring the supervising physician's (or other practitioner's) physical presence, the temporary policy permitted a supervising physician (or other practitioner) to be considered "immediately available" through virtual presence using two-way, real-time audio/visual technology for diagnostic tests, incident-to services, pulmonary rehabilitation services, and cardiac and intensive cardiac rehabilitation services, as well as certain hospital outpatient services. CMS finalized its proposal to continue this flexibility through December 31, 2025.

CMS also finalized its proposal to make permanent the virtual presence flexibility for certain services valued under the PFS, given that these services typically are performed in their entirety by auxiliary personnel. These services are:

- Services furnished incident to a physician's 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."
- Services described by CPT code 99211 (Office or other outpatient visit for the E/M of an established patient that may not require the presence of a physician or other qualified healthcare professional).

For CY 2024, CMS extended the policy that allowed teaching physicians to have a virtual presence in all teaching settings only in clinical instances when the service was furnished virtually (for example, a three-way telehealth visit, with all parties in separate locations). This allowed teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment was sought, through audio/video real-time communications technology, in all residency training locations. CMS extended this policy through December 31, 2025.



Telehealth Originating Site Facility Fee Payment

Key Takeaway: CMS updated the originating site facility fee to \$31.01.

Each year, the originating site facility fee for telehealth services is increased by the percentage increase in the MEI. The final MEI increase for CY 2025 is 3.5% and is based on the expected historical percentage increase of the 2017-based MEI. Therefore, for CY 2025, the final payment amount for HCPCS code Q3014 (telehealth originating site facility fee) is \$31.01.

Quality Payment Program

Under the QPP, eligible clinicians can be subject to payment adjustments based on performance under MIPS, or they can participate in the Advanced Alternative Payment Model (APM) track. Eligible clinicians in MIPS will have payments increased, maintained, or decreased based on relative performance in four categories: quality, cost, promoting interoperability, and improvement activities. CMS has also implemented a new alternative to traditional MIPS, the MVPs. While MVPs are currently optional, CMS continues to signal its intent to sunset traditional MIPS and make MVPs mandatory at some point going forward.

QPP: Merit-Based Incentive Payment System

Key Takeaway: CMS maintained the program threshold required to avoid a MIPS penalty and receive a positive payment adjustment.

To avoid a negative adjustment and be eligible for a positive payment adjustment, a provider’s total MIPS score must reach a performance threshold. For 2025, CMS once again maintained the MIPS performance threshold of 75 points. Historically, CMS has increased the MIPS performance threshold, but during the COVID-19 PHE, the agency maintained a 75-point threshold for consecutive years, allowing MIPS participants to avoid additional quality reporting challenges.

Based on the policies in the final rule, including maintaining the threshold at 75 points and the cost scoring policy (highlighted below), CMS believes that more than three-quarters of clinicians (77.5%) will receive a positive adjustment in performance year 2025/payment year 2027, and the mean score will be 86.4 points. MIPS is a budget-neutral program, so CMS uses the negative payment adjustments to fund the pool of positive payment adjustments. Since CMS estimates that most clinicians will avoid a negative payment adjustment and receive a positive payment adjustment, CMS estimates that the mean positive adjustment will only be 1.31% in performance year 2025/payment year 2027. For context, CMS recently released performance numbers for performance year 2023/payment year 2025 and found that the mean 2023 MIPS final score was 82.91 points and the mean payment adjustment was 0.56%. The maximum 2025 MIPS positive payment adjustment was only 2.15% (for clinicians who received a final score of 100 points).

The MIPS performance category weights are specified in statute and have not changed from the previous year.

CMS finalized its proposal to allow clinicians to request reweighting for the quality, improvement activities, and/or promoting interoperability

performance categories where data are inaccessible and unable to be submitted for reasons outside of

Performance Category	PY 2024 Weight	PY 2025 Weight
Quality	30%	30%
Cost	30%	30%
Promoting Interoperability	25%	25%
Improvement Activities	15%	15%



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the clinician's control because the clinician delegated submission of the data to a 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.

Quality Category

CMS finalized a total of 195 quality measures in its quality inventory (a reduction from the current 198).⁶ Specific measures are outlined in more detail in the QPP fact sheet and include:

- Addition of seven new measures (CMS did not finalize the Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer and Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer measures) (see Appendix D).
- Removal of 10 quality measures from the MIPS quality measure inventory (see Appendix E).
- Substantive changes to 66 existing quality measures.

CMS will maintain the data completeness criteria threshold of at least 75% through the 2028 performance period, creating stability in the quality reporting requirements.

MIPS participants have previously suggested that CMS revise its policy for removing or limiting the points for certain quality measures the agency has deemed as "topped out" or where performance has peaked or achieved a relatively high performance. CMS acknowledged this problem for certain specialties that have limited measure choice and a high proportion of topped-out measures, and which lack measure development. CMS will therefore remove the seven-point cap for certain topped-out measures, beginning with the CY 2025 performance period/2027 MIPS payment year. The 97th percentile performance rate will then correspond to 7.5 measure achievement points. CMS will conduct an analysis annually to determine which specialty measure sets are impacted by limited measure choice and which measures should be subject to the scoring cap exemption. The fact sheet contains the list of measures that meet the criteria specified above for 2025. Specialty sets impacted by limited measure choice include pathology, anesthesiology, diagnostic radiology, and radiation oncology.

Cost Category

CMS finalized a significant change to the cost scoring methodology starting in the 2024 performance period/2026 MIPS payment year. The final scoring methodology will use a new scoring distribution in which the median cost for a measure will be set at a score derived from the performance threshold established for that MIPS payment year. This differs from the current scoring methodology, where the benchmark is based on average performance of all MIPS eligible clinicians during that same performance period, which has meant that participants have not known how they will potentially be scored. For example, for the CY 2024 performance period, the median will be set at 7.5 and benchmark point ranges will then be calculated based on standard deviations from the median. CMS's analysis shows that this change for MIPS eligible clinicians assessed on at least one cost measure and receiving a cost performance category score will increase by 3.89 points and will not negatively impact MIPS eligible clinicians whose average costs for a specific cost measure are around the median. As noted, CMS believes that this policy change will lead to overall higher MIPS performance scores and more clinicians surpassing the 75-point performance threshold.

CMS also finalized its proposal to add a new cost measure exclusion policy beginning with the CY 2024 performance period where "errors" in addition to "significant changes" will be included as a reason to exclude a cost measure. CMS will exclude a cost measure if the significant changes or errors affect the

⁶ Note that qualified clinical data registry measures are approved outside the rulemaking process and are not included in this total.



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performance period (including if such issues occurred outside of the performance period, but otherwise affect the performance period).

Previously, CMS had no established process for removing the MIPS cost measures. This rule outlines factors the agency may consider when removing cost measures, including the following:

- It isn't feasible to implement the measure specifications.
- The measure steward is no longer able to maintain the cost measure.
- The implementation costs or negative unintended consequences associated with a cost measure outweigh the benefit of its continued use in the MIPS cost performance category.
- The measure specifications don't reflect current clinical practice or guidelines.
- A more applicable measure is available, including a measure that applies across settings, applies across populations, or is more proximal in time to desired patient outcomes for the particular topic.

CMS may retain a cost measure that meets one or more of these criteria if the agency determines the benefit of retaining the measure outweighs the benefit of removing it.

With respect to the actual cost measures, CMS added six episode-based cost measures beginning with the 2025 performance period with a 20-episode case minimum:

- An acute inpatient medical condition measure (respiratory infection hospitalization).
- Five chronic condition measures (chronic kidney disease, ESRD, kidney transplant management, prostate cancer, and rheumatoid arthritis).

The rule substantively updated two existing episode-based cost measures so that their specifications reflect reevaluated versions: cataract removal with intraocular lens implantation (currently named routine cataract with intraocular lens implantation) and inpatient percutaneous coronary intervention (currently named ST-elevation myocardial infarction percutaneous coronary intervention).

Improvement Activities

Previously, CMS classified improvement activities as either medium-weighted or high-weighted, with the latter earning twice the number of points. This rule removed activity weightings to simplify scoring and complement ongoing efforts to refine and improve the measure inventory. The rule also reduced the number of activities clinicians must attest to completing: one required activity for those in MVPs and clinicians, groups, and virtual groups with small practice, rural, non-patient-facing or health professional shortage area special status. All other clinicians, groups, and virtual groups must attest to two activities.

CMS will add two new activities (see Appendix F), modify one existing activity (see Appendix G), and remove four activities (see Appendix H).

Promoting Interoperability

In the past, CMS has allowed certain participants to not be scored in the promoting interoperability category and to re-weight the other MIPS categories. CMS will not continue automatic reweighting for clinical social workers in the CY 2025 performance period/2027 MIPS payment year. Automatic reweighting will only apply to MIPS eligible clinicians, groups, and virtual groups with the following special statuses: ambulatory-surgical-center-based, hospital-based, non-patient-facing, or small practice.



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Data Submission

To submit MIPS data, clinicians currently can use health information technology vendors or qualified clinical data registries and qualified registries. For the first time, CMS clarified policies for instances when there are multiple quality submissions. Where there are multiple quality submissions for an individual clinician, group, subgroup, or virtual group from *different organizations* (for example, from a qualified registry and from the practice administrator), CMS will calculate and score each submission received and assign the higher of the scores. For multiple data submissions received for an individual clinician, group, subgroup, or virtual group from the *same organization* (for example, from two practice administrators), CMS will score the most recent submission, meaning the new submission will override a previous submission (of the same submission type) from the same organization.

QPP: MIPS Value Pathways

Key Takeaway: CMS finalized six new MVPs and reiterated its intention to sunset traditional MIPS and make MVPs mandatory at some point going forward.

The MVPs are a participation option to motivate clinicians to move away from reporting on self-selected activities and measures (traditional MIPS) and towards an aligned set of measure options designed to be meaningful to patient care, better connect measures across MIPS categories, and be more relevant to a clinician's scope of practice. Over the years, participation in traditional MIPS has been criticized as expensive and time consuming with low positive payment adjustments as a reward, and as having an uncertain impact on patient care. At the same time, some stakeholders have raised concerns about sunsetting MIPS because MVPs are untested and it is unclear whether there will be MVP options for all participants. In the CY 2022 final rule, CMS finalized a proposal to launch the MVPs in 2023, set an implementation timeline, and defined MVP criteria. CMS then launched the option for MVPs with 12 different pathways⁷ reflecting various specialties and care settings.

In this rule, CMS finalized six new MVPs: ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care. A total of 21 MVPs are now available for the CY 2025 performance period/2027 MIPS payment year (CMS consolidated two neurology-focused MVPs into a single neurological MVP). For more information on these MVPs, review the [2025 Final MVPs Guide](#).

MVP Implementation Timeline

The MVP program remains a voluntary option to provide time for MIPS eligible clinicians to familiarize themselves with MVPs and begin preparing their practices for participation. In other documents and presentations, CMS has suggested that it will eventually sunset MIPS and move clinicians to MVPs, but has moved away from an explicit date for this transition to occur.

In this year's proposed rule, CMS stated again that it aims to have sufficient MVPs to allow reporting by all clinicians in MIPS, sunset traditional MIPS, and transition fully to MVPs. CMS sought comment on, but did not propose, the 2029 performance period as the potential timeline for completing the transition to MVPs (and sunsetting traditional MIPS). In the final rule, CMS reiterated its intention to sunset traditional MIPS and make MVPs mandatory, but noted that it will establish a timeline for doing so in future rulemaking.

⁷ The 12 MVPS previously established by CMS are advancing cancer care, optimal care for kidney health, optimal care for patients with episodic neurological conditions, supportive care for neurodegenerative conditions, promoting wellness, advancing rheumatology patient care, coordinating stroke care to promote prevention and cultivate positive outcomes, advancing care for heart disease, optimizing chronic disease management, adopting best practices and promoting patient safety within emergency medicine, improving care for lower extremity joint repair, and patient safety and support of positive experiences with anesthesia.



Advanced APM Track

Key Takeaway: Congress must act by the end of the year to extend the incentive payment for clinicians participating in Advanced APMs.

MACRA included a 5% incentive payment for clinicians participating in Advanced APMs through the 2022 performance year/2024 payment year. Starting in performance year 2024/payment year 2026, MACRA also provides for two different CFs depending on Advanced APM participation: qualifying participants in Advanced APMs will receive a differentially higher 0.75% update to the CF (compared to the general 0.25% update to the CF) each year.

In December 2022, Congress extended availability of the Advanced APM incentive payment for one year, allowing eligible clinicians to receive a 3.5% (down from the original 5%) incentive payment in the 2023 performance year/2025 payment year. The extension avoided a one-year gap in which there otherwise would have been no statutory payment incentive to participate in an Advanced APM. In the CAA, 2024, Congress once again extended the incentive, allowing eligible clinicians to receive a 1.88% incentive payment (coupled with the differentially higher 0.75% update to the CF) for the 2024 performance year/2026 payment year.

Absent further congressional action, the Advanced APM incentive payments will expire at the end of 2024. While legislation ([H.R. 5013](#)) has been introduced to restore the Advanced APM incentive payments to 5% for two years, it is unclear whether this legislation (or any other short-term extension of the incentive payments at a lower level) will be included in an end-of-year healthcare legislative package. If the incentive payments are not extended, Advanced APM participants will only receive the differentially higher 0.75% (compared to 0.25%) update to the CF each year going forward.

In the final rule, CMS declined to finalize proposals that would have modified how the agency determines whether a provider is a qualifying participant eligible for incentive payments. CMS anticipates proposing a comprehensive approach to qualifying participant determination in future rulemaking.

Medicare Shared Savings Program

CMS finalized several changes to the MSSP that are intended to further advance Medicare's value-based care strategy of growth, alignment, and equity. As of January 1, 2024, the MSSP had 480 accountable care organizations (ACOs) providing care to more than 10.8 million beneficiaries. ACOs are now delivering care to almost 50% of patients with traditional Medicare. CMS expects that the MSSP will increase the number of beneficiaries assigned to ACOs by up to four million over the next several years. The agency noted that increasing MSSP participation (particularly in rural and underserved areas), promoting equity, and advancing alignment across accountable care initiatives are central to the agency's goal of having 100% of traditional Medicare beneficiaries in a care relationship with accountability for quality and total cost of care by 2030. Major changes to the MSSP included in the final rule are outlined below.

Prepaid Shared Savings

Key Takeaway: CMS finalized prepaid shared savings for eligible ACOs to facilitate care investments.

CMS will establish a new "prepaid shared savings" option for eligible ACOs with a history of earning shared savings. Eligible ACOs that apply and are approved will receive advances (in quarterly payments) of earned shared savings that they can use to make investments to aid beneficiaries, such as direct beneficiary services and improved care coordination and quality through staffing or healthcare infrastructure. Eligible ACOs include those participating in Levels C – E of the BASIC track or in the



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ENHANCED track with consistent prior success in earning shared savings.

At least 50% of the prepaid shared savings must be spent on direct beneficiary services (not otherwise payable in traditional Medicare) that are evidence-based and medically appropriate for the beneficiary based on clinical and social risk factors. ACOs can work with community-based organizations to provide services to beneficiaries using prepaid shared savings. Additionally, up to 50% of the prepaid shared savings can be spent on staffing and healthcare infrastructure. ACOs that receive prepaid shared savings will repay them through earned shared savings, similar to ACOs receiving advance investment payments. However, ACOs receiving prepaid shared savings will be required to directly repay any outstanding balance to CMS at the end of their agreement period if the ACO is unable to repay that balance through earned shared savings.

ACOs will be able to apply to participate in the prepaid shared savings payment option during the annual application cycle, and the initial application will be for a January 1, 2026, start date. There will also be a one-time exception for ACOs renewing in 2025 to apply to participate in prepaid shared savings beginning on January 1, 2026.

Health Equity Benchmark

Key Takeaway: CMS finalized a health equity benchmark adjustment to encourage ACOs to serve rural and underserved communities.

To provide a greater financial incentive for ACOs to serve more beneficiaries from underserved communities, and to encourage practices already serving higher proportions of beneficiaries from underserved communities to enter and remain in the MSSP, CMS adopted a health equity benchmark adjustment (HEBA). For agreement periods beginning on January 1, 2025, and in subsequent years, CMS will adjust an ACO's historical benchmark using a HEBA based on the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy or who are dually eligible for Medicare and Medicaid. The HEBA provides a third method of upwardly adjusting an ACO's historical benchmark, and CMS will adjust the ACO's historical benchmark using the highest of three values: a positive regional adjustment, a prior savings adjustment, or a HEBA.

In response to stakeholder input, CMS will allow more ACOs with above average proportions of underserved beneficiaries to be eligible to receive a HEBA. Under the finalized calculation methodology, to be eligible for the HEBA an ACO must have at least 15% (instead of the proposed threshold of 20%) of its assigned beneficiaries enrolled in the Medicare Part D low-income subsidy or be dually eligible for Medicare and Medicaid. CMS noted that increasing beneficiary access to providers participating in ACOs in rural and other underserved areas remains a priority, and the prepaid shared savings option is intended to operate synergistically with the HEBA.

APM Performance Pathway Plus

Key Takeaway: CMS finalized an APM Performance Pathway (APP) Plus quality measure set and incentives to report via electronic clinical quality measures (eCQMs).

To promote alignment among CMS's quality programs and adoption of the Universal Foundation measure set, CMS finalized (with some modifications) the adoption of an APP Plus quality measure set that aligns with the Universal Foundation quality measures. CMS noted that this policy will better align the quality measures reported by MSSP ACOs with the Medicaid Core Sets, the Marketplace Quality Rating System, and Medicare Advantage and Part D Star Ratings (which have previously adopted or are in the process of adopting the quality measures in the Universal Foundation measure set). For performance year 2025 and subsequent performance years, MSSP ACOs will be required to report the APP Plus quality measure set. The APP quality measure set will no longer be available for reporting by



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MSSP ACOs beginning in performance year 2025. Additional information on the final rule's CY 2025 QPP changes is available [here](#).

CMS noted that in finalizing the APP Plus quality measure set, the agency aimed to address commenters' concerns about increased burden. CMS modified the proposed phase-in schedule for incorporating measures into the APP Plus quality measure set, extended the eCQM reporting incentive to performance year 2025 and subsequent performance years, extended this incentive to ACOs reporting MIPS clinical quality measures (CQMs) in performance years 2025 and 2026, and finalized the complex organization adjustment (as proposed).

Measures

The APP Plus quality measure set will incrementally grow to 11 measures, consisting of the six measures in the existing APP quality measure set and five new measures from the Adult Universal Foundation measure set. These 11 measures will be incrementally incorporated into the APP Plus quality measure set from performance year 2025 through performance year 2028 (or the performance year that is one year after eCQM specifications become available for Quality IDs 487 (Screening for Social Drivers of Health) and 493 (Adult Immunization Status), whichever is later). ACOs will be required to report on all measures in the APP Plus quality measure set annually. The quality measures will phase-in as follows:

- **Six measures** (four eCQMs/MIPS CQMs/Medicare CQMs for ACOs Participating in the Shared Savings Program (Medicare CQMs), one administrative claims measure, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure) in performance year 2025.
- **Eight measures** (five eCQMs/MIPS CQMs/Medicare CQMs, two administrative claims measures, and the CAHPS for MIPS Survey measure) in performance year 2026.
- **Nine measures** (six eCQMs/Medicare CQMs, two administrative claims measures, and the CAHPS for MIPS Survey measure) in performance year 2027.
- **11 measures** (eight eCQMs/Medicare CQMs, two administrative claims measures, and the CAHPS for MIPS Survey measure) in performance year 2028 or the performance year that is one year after eCQM specifications become available for Quality IDs 487 (Screening for Social Drivers of Health) and 493 (Adult Immunization Status), whichever is later.

Collection Types

CMS will streamline the collection types available for ACOs reporting the APP Plus quality measure set to focus on eCQM and Medicare CQM collection types. To allow ACOs to continue to gain experience with all-payer measures and to allow more time before sunsetting MIPS CQMs as a collection type, MIPS CQMs will be an available collection type for ACOs reporting the APP Plus quality measure set in performance years 2025 and 2026. When calculating MIPS quality performance category scores, CMS will score ACOs on all required measures in the APP Plus quality measure set using the APP scoring policies. ACOs reporting Medicare CQMs will be scored using flat benchmarks for the measures' first two performance periods in MIPS. CMS noted that it anticipates sunsetting Medicare CQMs no sooner than five years from now, when CMS anticipates there will be widespread uptake of Fast Healthcare Interoperability Resources Application Programming Interface technology to aggregate data and report eCQMs. CMS stated that the agency is committed to working with ACOs to overcome barriers to digital quality measure reporting and will continue to monitor challenges – particularly for ACOs with small and specialized practices – regarding ACOs' ability to collect and generate data necessary to successfully transition and report eCQMs. While CMS declined to create a small and/or specialized practices exception for quality reporting (as exists in other quality reporting programs) or to modify data



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completeness thresholds, CMS noted that it will consider additional adjustments to address reporting challenges for ACOs with small and specialized practices in future rulemaking.

Complex Organization Adjustment

To account for the organizational complexities faced by virtual groups and APM entities (including MSSP ACOs) when reporting eCQMs, CMS will establish a complex organization adjustment beginning in the CY 2025 performance period, as proposed. Virtual groups and APM entities will receive one measure achievement point for each submitted eCQM that meets the data completeness and case minimum requirements. Each reported eCQM cannot score more than 10 measure achievement points, and the total achievement points (numerator) cannot exceed the total available measure achievement points (denominator) for the MIPS quality performance category. The complex organization adjustment for a virtual group and/or APM entity also cannot exceed 10% of the total available measure achievement points in the MIPS quality performance category. The adjustment will be added for each measure submitted at the individual measure level.

Extension of eCQM Reporting Incentive

To further encourage ACOs to transition to eCQMs, CMS will also extend the MSSP's eCQM reporting incentive to performance year 2025 and subsequent performance years. The eCQM reporting incentive helps ACOs (that report eCQMs) to meet the quality performance standard required to share in savings at the maximum rate. To align the incentive with CMS's decision to make MIPS CQMs available as a collection type for two additional performance years, CMS will also extend the reporting incentive to ACOs reporting MIPS CQMs in performance years 2025 and 2026.

Significant, Anomalous, and Highly Suspect Billing Activity

Key Takeaway: CMS finalized a policy to address significant, anomalous, and highly suspect (SAHS) billing activity.

As proposed, CMS will mitigate the impact of SAHS billing activity in CY 2024 and subsequent calendar years by excluding payment amounts related to SAHS billing from expenditure and revenue calculations for the relevant CY and from historical benchmarks. CMS will routinely examine billing trends and other relevant information raised through complaints made by ACOs and other interested parties. CMS plans to identify and monitor any codes that could potentially trigger this SAHS adjustment policy and will make a final determination regarding which codes (if any) warrant adjustments for the applicable CY shortly after the start of the following CY.

CMS anticipates that it will consider multiple criteria in determining whether SAHS billing activity warrants removal of the corresponding billing codes from MSSP financial calculations. Such criteria include whether a given HCPCS/CPT code exhibits a level of billing that represents a significant claims increase (either in claim volume or dollars), whether this increase has a national or regional impact (*i.e.*, does not impact only one or a few ACOs), and whether this increase represents an unexpected deviation from historical utilization trends that is not clearly attributable to reasonably explained changes in policy or the supply or demand for covered items or services.

While CMS anticipates that SAHS billing activity will be a rare occurrence, having a permanent policy in place will allow CMS to move quickly to adjust financial calculations, provide ACOs with greater certainty that they will not be held accountable for SAHS billing activity that is out of their control, and strengthen the integrity of the MSSP through fair and accurate payment. These provisions complement the approach finalized in a separately issued [final rule](#) that addressed SAHS billing activity associated with certain intermittent catheter supplies in CY 2023.



Improper Payments

Key Takeaway: CMS finalized a methodology to account for improper payments and finalized a process for ACOs to request the reopening of an initial determination of shared savings or losses.

In the proposed rule, CMS noted that the MSSP's existing financial methodology does not fully account for the impact of improper payments on program calculations. Under the current methodology, CMS lacks a mechanism to account for demanded overpayment determinations that adjust payment amounts after the three-month claims run-out period that applies in calculating performance year or benchmark year expenditures or aggregate overpayment amounts that do not result in a claim or line-item adjustments. CMS also lacks a mechanism to account for an improper amount identified in a settlement agreement between a provider or supplier and the government or in a court's judgment.

To address this, CMS finalized a calculation methodology to account for the impact of improper payments in MSSP financial calculations. CMS will adjust the historical benchmark to account for the impact of improper payments should CMS recalculate a payment determination and issue a revised initial determination for a performance year in a prior agreement period that corresponds to a benchmark year of the ACO's current agreement period.

CMS will also establish a process by which an ACO can request a reopening of an initial determination of shared savings or shared losses. CMS will provide additional information on the reopening request process, including the form and manner in which CMS must receive a reopening request, through future guidance. ACOs seeking to submit a reopening request prior to the issuance of this guidance are encouraged to submit detailed information in writing to CMS by email. CMS also finalized revisions to the MSSP regulations to clarify that CMS has discretion to determine whether to reopen a payment determination.

Eligibility

Key Takeaway: CMS finalized changes to MSSP eligibility requirements giving more time to ACOs that fail to maintain 5,000 assigned beneficiaries to remedy the issue.

Under the current rules, an ACO that fails to maintain 5,000 assigned beneficiaries during an agreement period may be terminated from the program and not be eligible to share in savings for that performance year. For performance years beginning on or after January 1, 2025, CMS will no longer require termination if an ACO's assigned population falls below 5,000 beneficiaries during the agreement period. Instead, the ACO will have until the time of agreement renewal to meet the 5,000-beneficiary threshold.

CMS believes this change will provide ACOs additional time and opportunities to recruit providers and increase their assigned population, rather than being required to exit the MSSP because of attribution.

Beneficiary Assignment

Key Takeaway: CMS finalized proposed revisions to the definition of primary care services, with one modification, to capture more of the services rendered by primary care providers.

CMS assigns beneficiaries to an ACO based on a beneficiary's use of primary care services. CMS finalized revisions to the definition of "primary care services" under the MSSP as proposed, with one exception. CMS finalized additions to the definition of primary care services to include the following:

- Safety Planning Interventions (HCPCS code G0560) when the base code is also included in the



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definition of “primary care service.”

- Post-Discharge Telephonic Follow-Up Contacts Intervention (HCPCS code G0544).
- Virtual Check-In Service (CPT code 98016), a replacement code for HCPCS code G2012.
- APCM Services (HCPCS codes G0556, G0557, and G0558).
- Cardiovascular Risk Assessment and Risk Management Services (HCPCS codes G0537 and G0538).
- Direct Care Caregiver Training Services (HCPCS codes G0541, G0542, and G0543).
- Individual Behavior Management/Modification Caregiver Training Services (HCPCS codes G0539 and G0540).

However, CMS included only one of the six proposed codes for Interprofessional Consultation Services (CPT code 99452) in the definition of “primary care services.” CMS determined that the other five services (CPT codes 99446 – 99449 and 99451) are typically furnished by consultative providers, not the beneficiary’s primary care provider.

Key Takeaway: CMS finalized giving precedence to claims-based assignment to disease- or condition-specific ACO models over voluntary alignment in MSSP.

CMS expanded the exception to MSSP’s voluntary alignment policy as proposed to allow beneficiaries to be assigned to entities participating in certain CMS Innovation Center ACO models. CMS will allow a voluntarily aligned beneficiary to be claims-based assigned to an entity participating in a disease- or condition-specific innovation model (e.g., Kidney Care Choices model) when that model uses claims-based assignment that is based on primary care and/or other services. CMS believes this change will allow beneficiaries with certain diseases to benefit from the focused care coordination that is innate to participation in such a model. These changes will be effective for the performance year starting on January 1, 2025, and subsequent performance years.

Beneficiary Notification

Key Takeaway: CMS finalized revisions reducing the burden on ACOs to comply with the beneficiary follow-up communication requirement.

To reduce administrative burdens, CMS modified beneficiary notification requirements, including the timing of the follow-up communication to a beneficiary who has received the required standard written notice. ACOs must notify beneficiaries about the ACO’s participation in the MSSP, the beneficiary’s ability to decline claims data sharing, and the beneficiary’s ability to select a provider for the purposes of voluntary alignment. ACOs are also required to provide an additional follow-up communication with a beneficiary who received the original notice to promote transparency and empower the beneficiary to make informed decisions in choosing a primary care provider and sharing their health information. Currently, this follow-up communication must be provided to the beneficiary no later than the earlier of the beneficiary’s next primary care service visit or 180 days from the date the original notice was provided.

Effective January 1, 2025, ACOs must provide the follow-up communication within 180 days of the original beneficiary notification, without having to consider when the beneficiary’s next primary care service will occur. CMS stated that this change comes in response to ACO feedback noting that ACOs do not always know when the beneficiary’s next primary care service will be, and in some cases it can be very soon after the beneficiary receives the original notice.



Key Takeaway: CMS finalized revisions that limit the distribution of notification to beneficiaries who are more likely to be assigned to the ACO.

For ACOs under preliminary prospective assignment with retrospective reconciliation, CMS will limit the beneficiaries who must receive the notice to those who are more likely to be assigned to the ACO. This change is expected to reduce burden on ACOs and confusion for beneficiaries, including those who ultimately would not be eligible to be assigned to such ACOs. CMS will implement these changes beginning on January 1, 2025.

Potential Higher Risk/Reward Track

Key Takeaway: CMS seeks comment on a participation option with higher risk and reward than is currently available under the ENHANCED track.

Currently, the ENHANCED track offers the highest level of risk and potential reward in the MSSP. CMS seeks comment from ACOs and other interested parties regarding the tradeoffs associated with a higher risk and reward option. CMS seeks input on design features, including a discount to the benchmark, tapered sharing arrangements, application of a symmetrical minimum savings rate and minimum loss rate of 0%, and changes to the weights used to calculate the regional adjustment to an ACO's historical benchmark.

Prescription Drug Inflation Rebate Program

Key Takeaway: CMS finalized policies to implement the Medicare Part B and Medicare Part D Inflation Rebate Programs.

CMS codified policies around rebates for certain Medicare Part B and Medicare Part D drugs for which drug companies raise prices faster than the rate of inflation, as required by the Inflation Reduction Act. CMS also finalized policies related to the method and process for reconciling rebate amounts for Part B and Part D rebatable drugs, a civil money penalty process for when a manufacturer fails to repay a rebate amount, and clarifications to rebate calculations in certain circumstances.

With respect to 340B drugs, CMS codified the removal of units of drugs for which the manufacturer provides a discount under the 340B Program from Part B inflation rebate calculations. For Part D, CMS did not finalize the estimation methodology it proposed. Instead, CMS will explore establishing a Medicare Part D claims data repository to comply with the statutory obligation for removal of 340B units from Part D drug inflation rebate calculations, starting January 1, 2026. CMS plans to continue exploring development of detailed policies and requirements related to any such repository in future rulemaking.

Other Proposals

Medicare Diabetes Prevention Program

Key Takeaway: CMS created further alignment with the Centers for Disease Control and Prevention (CDC) program, including definition changes that could impact "online" services.

The Medicare Diabetes Prevention Program (MDPP) is an evidenced-based behavioral intervention that aims to prevent or delay the onset of type 2 diabetes for eligible Medicare beneficiaries diagnosed with prediabetes. For CY 2025, CMS further streamlined administrative, compliance, and data reporting requirements. These changes include alignment with the CDC's [Diabetes Prevention Recognition Program](#) (DPRP). CMS also finalized an additional option for self-reporting weight in an MDPP distance learning session and removal of the MDPP bridge payment.



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The rule includes an addition of “in-person with a distance learning component,” adjustments to “combination with an online component,” and modifications to “online delivery.” For “online delivery,” CMS changes the term to “online” and defines it as “sessions that are delivered 100% through the internet via phone, tablet, or laptop in an asynchronous (non-live) classroom where participants are experiencing the content on their own time without a live (including non-artificial intelligence (AI)) Coach teaching the content.”

CMS also slightly adjusted the requirements for a virtual weight measurement. Previously, CMS allowed for submission through:

- Digital technology, such as scales that transmit weights securely via wireless or cellular transmission; or
- Self-reported weight measurements from the at-home digital scale of the MDPP beneficiary. These must be obtained during live, synchronous online video technology, such as video chatting or video conferencing, wherein the MDPP coach observes the beneficiary weighing themselves and views the weight indicated on the at-home digital scale. Alternatively, the MDPP beneficiary may self-report their weight by submitting to the MDPP supplier a date-stamped photo or video recording of the beneficiary’s weight, with the beneficiary visible in their home. The photo or video must clearly document the weight of the MDPP beneficiary as it appears on the digital scale on the date associated with the billable MDPP session.

CMS will continue these options, with a slight change within the self-reported option:

- The MDPP supplier may receive one or two date-stamped photos or a video recording of the beneficiary’s weight, with the beneficiary visible on the scale, submitted by the MDPP beneficiary to the MDPP supplier.

While CMS originally proposed allowing for submission of two photos, commenters thought that two photos was a new requirement. CMS clarified in the final rule that suppliers can receive one or two photos. Each photo or video must clearly document the weight of the MDPP beneficiary as it appears on the digital scale on the date associated with the billable MDPP session. If submitting two photos, one photo must show the beneficiary’s weight on the digital scale, the second photo must show the beneficiary visible in their home, and both photos must be date-stamped.

In CY 2024, CMS finalized that the extended flexibilities (through December 31, 2027) would continue to apply only to MDPP suppliers that have and maintain CDC DPRP “in-person” recognition, and that virtual-only suppliers were not permitted to furnish the services. For CY 2025, CMS clarified that MDPP suppliers can have and maintain either CDC’s “in-person” or the new “in-person with a distance learning component” CDC DPRP code.

CMS also finalized its proposals to remove bridge payments and to adjust limitations on make-up sessions that were finalized in CY 2024. The agency finalized its proposal to require MDPP suppliers to append a modifier -76 (*repeat services by same physician*) to any claim for HCPCS codes G9886 or G9887 to identify an MDPP make-up session that was held on the same day as a regularly scheduled MDPP session. CMS initially proposed use of modifier -79 but after further review made a technical correction to finalize modifier -76 instead. CMS also finalized minor adjustments to current regulations to update outdated references and align with previous rulemaking pertaining to MDPP terminology, payment structure, and requirements.



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

Key Takeaway: CMS finalized its proposal to expand clinical scenarios under which Medicare payment may be made for dental services inextricably linked to covered dialysis services for beneficiaries with ESRD.

In the CY 2023 final rule, CMS clarified and codified that Medicare payment under Parts A and B can be made when dental services are furnished in either the inpatient or outpatient setting when the dental services are inextricably linked to, and substantially related and integral to, the clinical success of other covered services.

For CY 2025, CMS finalized its proposal to expand the list of clinical scenarios under which Medicare payment may be made for dental services to include certain dental services associated with dialysis services for beneficiaries with ESRD. CMS finalized that Medicare Part A and B payment may be made for:

- Dental or oral examination in the inpatient or outpatient setting prior to, or contemporaneous with, Medicare-covered dialysis services for the treatment of ESRD.
- Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneous with, covered dialysis services in the treatment of ESRD.

Colorectal Cancer Screening

Key Takeaway: CMS finalized its proposal to expand coverage for colorectal cancer (CRC) screening.

In the CY 2023 final rule, CMS expanded the regulatory definition of CRC screening to include a complete CRC screening, which includes a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based CRC screening test returns a positive result. For CY 2025, CMS finalized its proposal to again update and expand the regulatory definition of CRC screening, including by:

- Removing coverage of barium enema as a screening method because this service is rarely used in Medicare and is no longer recommended as an evidence-based screening method.
- Adding coverage for the computed tomography colonography procedure.
- Adding coverage for Medicare covered blood-based biomarker CRC screening tests.
- Revising the regulatory text to clarify that CRC screening frequency limitations do not apply to the follow-on screening colonoscopy in the context of “complete CRC screening.”

Vaccine Administration

Key Takeaway: CMS finalized its proposal to expand coverage of hepatitis B vaccination.

Under Section 1861(s)(10) of the Social Security Act, Medicare Part B covers both the vaccine and its administration for specified preventive vaccines, including pneumococcal, influenza, hepatitis B, and COVID-19 vaccines.

For CY 2025, CMS finalized its proposal to expand coverage of hepatitis B vaccinations to include individuals who have not previously received a completed hepatitis B vaccination series and individuals whose previous vaccination history is unknown. A physician’s order will no longer be required for the administration of a hepatitis B vaccine under Part B, which will facilitate roster billing by mass immunizers



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for hepatitis B vaccine administration. CMS also finalized a policy to set payment for hepatitis B vaccines and their administration at 100% of reasonable cost in RHCs and FQHCs, separate from payment under the FQHC Prospective Payment System or the RHC All-Inclusive Rate methodology, to streamline payment for all Part B vaccines in those settings.

RFIs

The CY 2025 proposed rule included RFIs on several topics, including expanding the list of teaching physician services that can be furnished under the primary care exception and Medicare payment for services furnished in urgent care centers, behavioral health crisis stabilization units, certified community behavioral health clinics, and freestanding substance use disorder treatment facilities. In the final rule, CMS acknowledged the comments it received on these RFIs and stated that it will consider them for future rulemaking.

Conclusion

In summary, the CY 2025 PFS final rule creates an unstable financial outlook for physician payments going forward. The lack of an inflationary update means that clinicians continue to fall behind other Medicare payment systems. The need for refinements to the MIPS quality reporting program and the challenges in advancing the use of telehealth services also remain significant issues. Stakeholders will likely again turn to Congress to mitigate overall physician payment cuts and to address necessary flexibilities to promote virtual care. Any action by lawmakers on these issues is unlikely to be addressed until the end of the year, however, and the appetite to continuously patch physician payments remains unclear.

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