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MPFS Final Rule Cuts Physician Payments: Will It Last?

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released its finalized Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2025, aiming "to strengthen primary care, expand access to preventive services, and further access to whole-person care."[1] While the finalized fee schedule cuts payments to physicians, Congress is considering legislation to override the cut. This Health Capital Topics article discusses the provisions contained in the MPFS final rule, as well as the proposed "doc fix" legislation.

Payment Rate Updates for MPFS

The overall MPFS payment rates will be reduced by 2.93% in CY 2025.[2] Notably, CMS also anticipates provider expenses to increase by 3.6% in 2025, meaning the 2.93% reduction will effectively amount to a 6.4% cut.[3] The conversion factor will decline by $0.94, to $32.35 – a 2.83% reduction from 2024's conversion factor of $33.29 – marking the fifth straight year that CMS has decreased physician payment rates.[4] The conversion factor translates a relative value unit (RVU) – a geographically-adjusted measure of resources required to perform a procedure – into a payment amount for a given service.[5] This conversion factor is updated annually using a formula that accounts for: (1) the previous year's conversion factor; (2) the estimated percentage increase in the Medicare Economic Index (MEI) for the year (reflecting inflationary changes in office expenses and physician earnings); and (3) an update adjustment factor.[6] All physician services, except anesthesia services, use a single conversion factor.[7] The CY 2025 decrease "reflects the 0% update required by statute for CY 2025, the expiration of the 2.93% temporary increase in payment amounts for CY 2024 required by statute, and a small [0.02%] budget neutrality adjustment necessary to account for changes in valuation for particular services."[8]

Medicare Shared Savings Program (MSSP) Changes

CMS finalized several changes to the Medicare Shared Savings Program (MSSP). For the first time, accountable care organizations (ACOs) with a successful MSSP track record will be able to receive an advance on their earned shared savings. This change aims to "encourage ACO investment in staffing, health care infrastructure, and certain additional services for people with Medicare, such as dental, vision, hearing, healthy meals, and transportation."[9] CMS also adopted a health equity benchmark to encourage ACOs that serve Medicare and Medicaid beneficiaries located in rural and underserved areas.[10]

Regarding the MSSP financial benchmarking methodology, CMS finalized adjustments related to improper payments. Starting with CY 2024 billing activity, CMS will be able to take into account the impact of improper payments and mitigate the impact of significant, anomalous, and highly suspect (SAHS) billing activity during the annual financial reconciliation.[11]

Telehealth Changes

The *Consolidated Appropriations Act, 2023* temporarily extended telehealth flexibilities, which have been in place since the start of the COVID-19 public health emergency, until December 31, 2024.[12] CMS finalized the flexibilities it could under its authority with the 2025 MPFS Final Rule. For example, CMS will continue to allow certain practitioners to directly supervise auxiliary personnel via virtual means and allow teaching physicians to be virtually present when furnishing telehealth services involving residents in teaching settings.[13] Additionally, a number of services were added to the Medicare Telehealth Services List, including caregiver training services (on a provisional basis) and counseling and safety planning interventions for PrEP (on a permanent basis).[14] However, the power to permanently expand telehealth ultimately lies with Congress. Should Congress not act prior to January 1, 2025, geographic and location restrictions will return (i.e., Medicare beneficiaries across the U.S. will not be able to receive services in their home and other previously-disallowed locations), as will limitations on the types of practitioners who can provide telehealth services to Medicare beneficiaries.[15] The one exception to these limitations is behavioral telehealth, which can continue to be provided to the patient in their home.[16]

A number of bills are under consideration in Congress to permanently extend telehealth for Medicare beneficiaries. The most recent legislation, *Telehealth Modernization Act of 2024*, unanimously advanced out of the House Committee on Energy and Commerce in September 2024.[17] The bill would extend telehealth flexibilities – namely restrictions relating to originating and geographic sites, provider type, and covered services – for two years, and permanently allow federally qualified health centers (FQHCs) and rural health clinics

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(Continued on next page)

(RHCs) to provide telehealth services for adequate reimbursement.[18]

Advanced Primary Care Management (APCM) Services

CMS established coding and payment for a new set of Advanced Primary Care Management (APCM) services.[19] Starting January 1, 2025, physicians and non-physician practitioners (NPPs) who participate in advanced primary care models can bill the following APCM service codes:

(1) G0556, for patients with one chronic condition;

(2) G0557, for patients with two or more chronic conditions; and

(3) G0558, for patients with two or more chronic conditions and status as a Qualified Medicare Beneficiary.[20]

The services include parts of existing care management and communication technology-based services and reflect the essential parts of advanced primary care delivery, including chronic care management, transitional care management, and principal care management.[21] Further, the codes are not time-based, unlike existing care management codes, so as to reduce the administrative burden.[22] CMS notes that these new codes "represent a step towards 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, by paying for care in larger units of service, and also help drive accountable care."[23]

Other Provisions

Other provisions finalized by CMS for 2025 include:

(1) Codifying the *Inflation Reduction Act of 2022*'s mandate that drug companies pay "inflation rebates" if they raise prices for certain Medicare Part B and D drugs faster than the rate of inflation;

(2) Allowing outpatient providers to bill an Evaluation and Management (E/M) visit complexity add-on code when the E/M base code is accompanied by an annual wellness visit, vaccine administration, or other preventative service; and

(3) Technology flexibilities for opioid treatment programs (OTPs), including allowing OTP intake and initiation with methadone to be furnished via telehealth and allowing audio-only visits for follow-up appointments.[24]

Industry Reaction

National provider associations uniformly condemned the MPFS final rule's cuts to physician payments. The American Medical Association (AMA) criticized both CMS and congress, stating, "To put it bluntly, Medicare plans to pay us less while costs go up. You don't have to be an economist to know that is an unsustainable trend…"[25] America's Physician Groups (APG) also expressed their disappointment, pivoting to urging Congress to "blunt the crippling effect of the fee cuts."[26] Similarly, the American Group Management Association (AMGA) communicated its concern that "the cut may force AMGA members to lay off staff and clinicians, further exacerbating patient access to care; not accept new Medicare beneficiaries as patients; and delay investments in social drivers of health."[27] The AMGA also implored Congress to prevent the cuts from taking effect by passing legislation before the end of the year.[28] The Medical Group Management Association (MGMA) weighed in, stating that "CMS and Congress have once again overlooked the sobering financial realities facing our nation's medical practices…further increasing the gap between practice expenses and reimbursement rates. Today's final rule throws the financial viability of physician practices into question and threatens beneficiary access to care."[29] In addition, MGMA sent a letter to congressional leaders imploring them to resolve the significant reimbursement challenges faced by providers. In particular, MGMA asked for leaders' consideration of three issues: "averting the finalized cut to Medicare payment and providing an inflationary update for 2025, passing prior authorization reform, and extending telehealth flexibilities."[30]

Meanwhile, associations commended other MPFS provisions. MGMA applauded CMS for finalizing several telehealth policies and APG and the National Association of ACOs (NAACOS) expressed their general approval of the MSSP changes.[31] However, NAACOS remains "concerned about unresolved issues that threaten ACO participation in the Shared Savings Program," namely "increasingly reduced financial targets over time" and new quality reporting requirements.[32]

In response to the urging of provider associations, a new, bipartisan bill was recently introduced in the U.S. House of Representatives that would increase physician pay by 4.73%,[33] turning CMS's 2.93% pay cut into a 1.80% increase (which equates to half of the Medicare Economic Index for 2025[34]). The bill has garnered support from 155 medical organizations, including the American Medical Association (AMA) and MGMA.[35]

When adjusted for inflation, MPFS reimbursement has declined 29% since 2001.[36] Similarly, MGMA data on physician practices indicate that total operating cost per full-time equivalent (FTE) physician increased by more than 63% between 2013 and 2022, while the MPFS conversion factor increased by only 1.7% over the same timeframe.[37] Physicians have been sounding the alarm on Medicare reimbursement challenges for years. In response to a 2023 survey conducted by MGMA, "87 percent of medical group practices said reimbursement not keeping up with inflation would impact current and future Medicare patient access," and "92 percent of medical groups reported an increase in operating costs in 2024."[38] While provider associations have been calling for a more comprehensive overhaul of physician payment updates, to avoid such end-of-the-year overrides, it is unlikely that any legislation will be passed this year given there are only 12 legislative days left in 2024 (beginning December 1st), meaning that any wholesale changes to the MPFS are likely delayed for at least another year.

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