HEALTH Endeavors

INTELLIGENCE BRIEF | NOVEMBER 2024

CMS Releases Final 2025 Medicare Fee Schedule with Meaningful Updates for Value-Based Care

This brief focuses on the value-based care-related provisions in the 2025 final Medicare Physician Fee Schedule, beginning with a **detailed summary of the changes to the MSSP**, followed by **other notable VBC-related provisions,** and concluding with **the implications of these changes for ACO participants and expectations for the future.**

Background

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the anticipated final rule for the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2025. The annual MPFS provides updates to physician payment policies, including new fee-for-service (FFS) codes and payment rates for Part B services delivered to Medicare beneficiaries, as well as other changes to CMS payment initiatives such as the Medicare Shared Savings Program (MSSP).

In this year's 3,088-page rule, CMS is finalizing a pay cut for physicians for the fifth year in a row—in the form of a 2.83% decrease in the conversion factor—which has attracted significant industry backlash and may drive potential future Congressional action *(discussed further in the Implications section).*

Despite near-universal frustration with the physician payment rates—which are statutorily required to be budget neutral and do not account for inflation, among other issues—other elements of the rule were welcomed by the industry, including updates to strengthen the MSSP and new codes for high-value services – the focus of this brief.

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Historical Context for MSSP Changes

CMS frequently uses the annual Medicare Physician Fee Schedule as a vehicle for introducing changes to the MSSP, CMS' largest, longest-running accountable care initiative—which currently includes 480 accountable care organizations (ACOs) involving 634,000 providers caring for 10.8 million beneficiaries across the country—some years making only minor adjustments to quality measures while other years see meaningful changes to program rules and methodology. Building on the material MSSP updates introduced in the CY23 and CY24 MPFS regulations, the final rule for 2025 includes a number of notable changes to the MSSP and offers signals to the industry regarding CMS' priorities for potential future adjustments to the important program (*see* Table 1).

The updates to the program in recent years are designed to reverse the stagnation in participation that began in 2019 following the "Pathways to Success" overhaul which accelerated the transition to downside risk, leading to a spike in dropouts and a decline in the number of new ACOs joining the program. **Bolstering the MSSP and accelerating adoption is a key element of CMS' strategy, as they work to achieve their goal of having 100% of Medicare beneficiaries in accountable care relationships by 2030**. For example, CMS expects that the changes made to the MSSP through the final rules published in 2023 and 2024 alone will add four million more beneficiaries to the program by 2034, with even further growth expected due to the changes made in this year's rule. CMS anticipates that these changes will also improve program performance, estimating that the 2025 provisions will reduce spending by an additional $200 million between 2025 through 2034.

Table 1: Summary of Major MSSP Updates included in the 2023, 2024, and 2025 MPFS Final Rules

2023	2024	2025
• Introducing Advance Investment Payments (AIPs) to provide upfront funding to eligible, new ACOs • Extending the time select ACOs can spend under upside-risk only MSSP tracks • Expanding eligibility criteria for low revenue ACOs to qualify for shared savings • Implementing benchmarking changes to reduce the effect of ACO performance on historical benchmark, including accounting for prior savings and an administrative component to benchmarking • Reducing the impact of negative regional adjustment • Reverting to the sliding scale approach for determining shared savings/losses • Introducing the health equity adjustment for quality scores • Reducing administrative burden regarding marketing materials and data sharing	• Adding a "step three" to beneficiary assignment incorporating advanced practitioners, designed to increase the number of beneficiaries assigned to ACOs • Implementing various efforts to align MSSP and MIPS • Making benchmark updates to cap regional risk score growth and eliminate negative regional adjustment on benchmark to incentivize ACOs serving high-cost beneficiaries • Refining AIP policies to prepare for implementation	• Adding the Prepaid Shared Savings option to provide upfront funding to established ACOs • Adding the Health Equity Benchmark Adjustment • Accounting for anomalous and fraudulent billing • Updating quality measures to align with the Universal Foundation • Incentivizing the transition to eCQMs • Adding flexibility for small ACOs to remain in the MSSP • Updating beneficiary assignment policies • Reducing administrative burden regarding beneficiary notification

Summary of Final MSSP-Related Provisions

The major MSSP-related provisions of the 2025 final rule can be organized into three broad categories: 1) **Payment & Benchmarking**, 2) **Quality Performance**, and 3) **Beneficiary Assignment & Notification**. Overall, the changes intend to bolster the program by attracting and retaining ACOs by providing additional funding opportunities, implementing favorable payment and other policy adjustments, and easing administrative burdens.

Payment & Benchmarking Changes

In short, the final updates to MSSP payment and benchmarking rules include the creation of a prepaid shared savings option, addition of a Health Equity Benchmark Adjustment, and making permanent new policies for addressing anomalous billing issues – all welcome changes by the ACO community, though some have voiced frustrations that CMS could have made further updates to address the long-term sustainability of benchmarks *(see Industry Response below)*.

Prepaid Shared Savings	Health Equity Benchmark Adjustment	Anomalous Billing
Providing optional upfront funding to invest in care delivery, staffing, and infrastructure for eligible renewing ACOs with a history of shared savings.	Providing an upward adjustment to benchmarks for ACOs providing care to underserved populations.	Creating a permanent policy dictating how CMS will address instances of large scale, fraudulent billing and finalizing rules around redeterminations following improper payments.

Prepaid Shared Savings Option

In 2023, CMS introduced Advance Investment Payments (AIPs) which provided eligible, new MSSP ACOs with upfront funding to invest in the care delivery, infrastructure, and staffing needed to support population health management. By providing upfront access to funds and allowing early investment in these areas, rather than waiting for shared savings checks to arrive, CMS hopes to attract small and safety net providers who would otherwise be unable to participate. In 2024—the first year AIPs were implemented—19 ACOs received them, and other ACOs that did not qualify began asking CMS to expand the eligibility criteria for AIPs to a broader range of ACOs *(see Table 2)*.

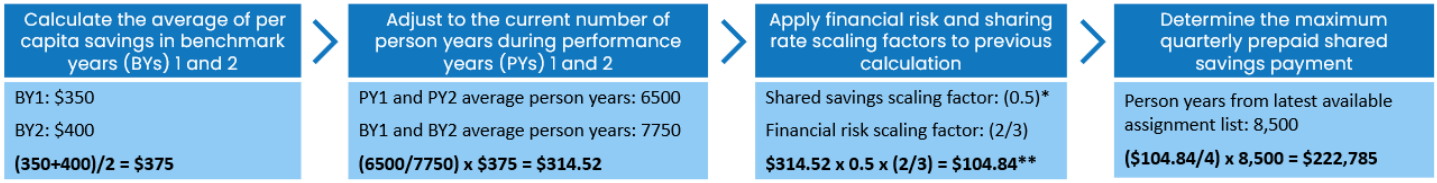
However, because CMS wishes to evaluate AIPs as designed, rather than expand eligibility, the agency has **created a new "prepaid shared savings" option** for **renewing ACOs** with a **history of earning shared savings** that **participate in a downside risk track** (Levels C-E of the BASIC track or the ENHANCED track). This option will be available beginning in 2026.

To be eligible for prepaid shared savings, ACOs must be **renewing** (second or subsequent agreement period), in a **downside risk track**, and must have:

- Earned a shared savings payment for the most recent performance year in the prior agreement period
- A positive prior savings adjustment for the current agreement period
- No outstanding shared losses or AIPs to be repaid

For eligible ACOs electing to receive prepaid shared savings, CMS will provide a quarterly advance on savings that will ultimately be repaid through future earned shared savings. The **maximum amount of funding will be calculated using the ACO's two most recent years of per capita savings**, though ACOs will have the option to receive lower payments, if desired. The detailed calculation process is shown in *Figure 1*. As with AIPs, CMS will share preliminary information about prepaid shared savings amounts with ACOs during the application process.

Figure 1: Prepaid Shared Savings Calculation Example



**The shared savings scaling factor is 0.5 for all ACOs, regardless of the shared savings rate in their chosen track*
***This number will be capped at 5% of national assignable per capita FFS expenditures for assignable beneficiaries*

Also consistent with AIPs, CMS will dictate—to some degree—how prepaid shared savings funds are spent and will require ACOs to submit a spending plan. At least **half of the funds must go toward direct beneficiary services that are not already paid for by CMS**. This could include services addressing health-related social needs (HRSNs) (e.g., meals and transportation); dental, vision, and hearing services; and Part B cost-sharing reductions, to name a few. The **remainder of the funds must be spent on investments in infrastructure and staffing**. Payments *cannot* be used for management company or parent company profit, performance bonuses, provision of medical services covered by Medicare, cash or cash equivalent payments to patients, items or activities unrelated to ACO operations or care of beneficiaries, or the repayment of any shared losses incurred. Payments must be spent in the 5-year agreement period in which they are received, and any unspent funds must be returned to Medicare. CMS will rely on existing repayment mechanisms (e.g., surety bond, line of credit, funds in escrow) to recollect prepaid shared savings.

Table 2: Comparison of upfront funding options available to MSSP ACOs (AIPs, Prepaid Shared Savings, and ACO PC Flex Model)

	AIPs	Prepaid Shared Savings Option	ACO PC Flex Model
Description	Optional upfront payment for qualifying MSSP ACOs	Optional upfront payment for qualifying MSSP ACOs	CMS Innovation Center (CMMI) model testing upfront payment and primary care capitation for select MSSP ACOs
Eligibility	New, inexperienced, and low-revenue ACOs	Renewing ACOs in downside risk tracks with a history of earning shared savings	Up to 130 low-revenue ACOs
Amount	One-time upfront shared savings payment of $250,000 plus per-beneficiary-per-quarter payments	Quarterly funding calculated based on historic shared savings earned	One-time upfront shared savings payment of $250,000

Health Equity Benchmark Adjustment

Health equity has been a central priority of the Biden administration's health policy platform, including using alternative payment models as a vehicle for better understanding and addressing disparities and bringing accountable care to underserved populations. In 2023, CMS added a health equity adjustment to quality performance scores that provided up to 10 bonus points to high-performing MSSP ACOs serving a high proportion of underserved or dually eligible beneficiaries. Beginning in 2025, ACOs will also have the opportunity to benefit from a **new** Health Equity Benchmark Adjustment (HEBA) that can **increase an ACO's benchmark by up to 5%** (though CMS estimates the average increase would be only 1%). **With this addition, ACOs will now qualify for one of three potential upward benchmark adjustments**: 1) HEBA, 2) the Prior Savings Adjustment, or 3) the Positive Regional Adjustment – the latter two adjustments already being included in the existing MSSP methodology. For these three available benchmark adjustments, CMS will apply the whichever option provides the highest boost to an ACO's benchmark.

In the proposed rule, CMS suggested that ACOs with 20% of assigned beneficiaries either **enrolled in the Medicare Part D low-income subsidy (LIS)** or **dually eligible for Medicare and Medicaid** would qualify for the HEBA, but because ACOs can only benefit from one of three upward adjustments, only around 4% of ACOs (20 as of 2024) would end up benefitting from the HEBA. In the final rule, **CMS eased the barriers to qualifying for this adjustment**, **dropping the threshold to 15% of aligned beneficiaries** enrolled in Part D LIS or dual-eligible, which is expected to boost the number of ACOs receiving the HEBA to an estimated 7% of ACOs. In addition, utilization of HEBA will likely grow due to other changes made in prior years (e.g., extending the time ACOs can spend under upside-risk only MSSP tracks, expanding eligibility criteria for low revenue ACOs to qualify for shared savings) designed to attract the types of ACOs that would be more likely to benefit from the HEBA, such as FQHCs and other safety net providers.

Worth noting, CMS has already tested the health equity benchmark adjustment concept in ACO REACH and is now applying it to the MSSP, though there are key differences in how the adjustment will be implemented. First, while the health equity benchmark adjustment in ACO REACH can decrease benchmarks for ACOs serving a lower proportion of underserved beneficiaries, the MSSP's HEBA will only ever provide an upward adjustment. Additionally, the methodology for the adjustment will differ, as the adjustment must be determined in relation to the potential impact of the Prior Savings and Positive Regional adjustments to ensure ACOs receive the highest possible adjustment. Additionally, unlike the approach in ACO REACH, the MSSP's HEBA will not incorporate the Area Deprivation Index (ADI). *Figure 2* shows a theoretical example of how CMS will determine which benchmark adjustment to apply to MSSP ACOs beginning 2025.

Figure 2: Process for Determining Benchmark Adjustment with Example Figures

1. Determine the share of eligible beneficiaries	**2.** Calculate the HEBA Scaler*	**3.** Determine Prior Savings and Positive Regional adjustments	**4.** Subtract the higher of the two adjustments from the HEBA Scaler	**5.** Multiply this number by the share of eligible beneficiaries	**6.** Compare all three benchmark adjustment options	**7.** Add the highest adjustment to the eligible beneficiary benchmarks
60%	$600	Prior Savings = $200 Positive Regional = $100	$600 - $200 = $400	$400 x 0.6 = $240	HEBA = $240 Prior Savings = $200 Positive Regional = $100	$12,000 + $240 = $12,240

**5% of national per capita expenditures for eligible beneficiaries*

Anomalous Billing

In February 2024, industry groups uncovered a multi-billion dollar fraud scheme related to billing for urinary catheters, which increased 20-fold over a two-year period. The National Association of ACOs (NAACOs)—which brought the fraud to CMS' attention—noted how ACOs can be a helpful check for fraud and abuse as they are closely analyzing utilization and cost data. Following this discovery, ACO representatives penned letters to CMS, asking that fraudulent spending for these codes—which had increased some ACOs' total spending by up to 2%—be removed from ACO financial calculations. CMS ultimately issued an interim final rule that held ACOs harmless in 2024, adjusting expenditure calculations and historical benchmarks to account for the fraud.

Criteria to determine SAHS billing in the MSSP:

- A given code exhibits a level of billing that represents a significant increase in either volume or dollars and has a national or regional impact or significance
- Inaction would result in an imbalance between ACO performance year and historical benchmark year expenditures
- Use of payment amounts associated with SAHS billing could result in payment inaccuracies beyond the control of ACOs
- The claims in question may be disproportionately represented by Medicare providers or suppliers whose Medicare enrollment status has been revoked

In the 2025 MPFS final rule, **CMS finalized a permanent policy that details how the agency will proactively address similar fraud in future** years without requiring that CMS engage in additional rulemaking as was done for the catheter billing fraud. Now, **the agency will make a final determination early in a calendar year as to which codes meet the criteria for Significant, Anomalous, and Highly Suspect (SAHS) billing** and warrant exclusion and adjustments for the previous calendar year. CMS does not expect this to be a common occurrence, as the catheter fraud scheme was the first instance in the program's history that warranted this type of action.

Under the new rules, ACOs will also be able to request that CMS reopen payment determinations if improper payments are identified through a process that will be developed with input from ACOs. If an ACO would like to submit a reopening request before this official process is established, they may submit a request directly to CMS.

Quality Performance Changes

Building on a series of meaningful updates to MSSP quality measurement and performance in recent years, the 2025 final rule includes additional adjustments aimed at better aligning measures across programs and supporting ACOs in the transition to electronic reporting.

Universal Foundation Alignment	Quality Measure Reporting Mechanisms
Aligning MSSP quality measures with the set of Adult Universal Foundation measures and growing the number of metrics from six to 11 over a three-year period.	Retaining the MIPS CQM reporting option while extending existing incentives and adding new ones to encourage eCQM reporting.

Universal Foundation Alignment

In response to the longstanding burden imposed by quality measure misalignment, in 2023, CMS introduced the Universal Foundation to provide a consistent set of quality metrics to be used for quality measurement and reporting across the agency's program, consistent with its National Quality Strategy. As finalized in the 2025 MPFS rule, **CMS will now require ACOs to report on the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set** that aligns

with the Adult Universal Foundation quality measures. The number of measures will grow from six to 11, phased in between 2025 and 2028 (see *Figure 3)*, though CMS did postpone the timeline for adoption of some of the new measures in the final rule.

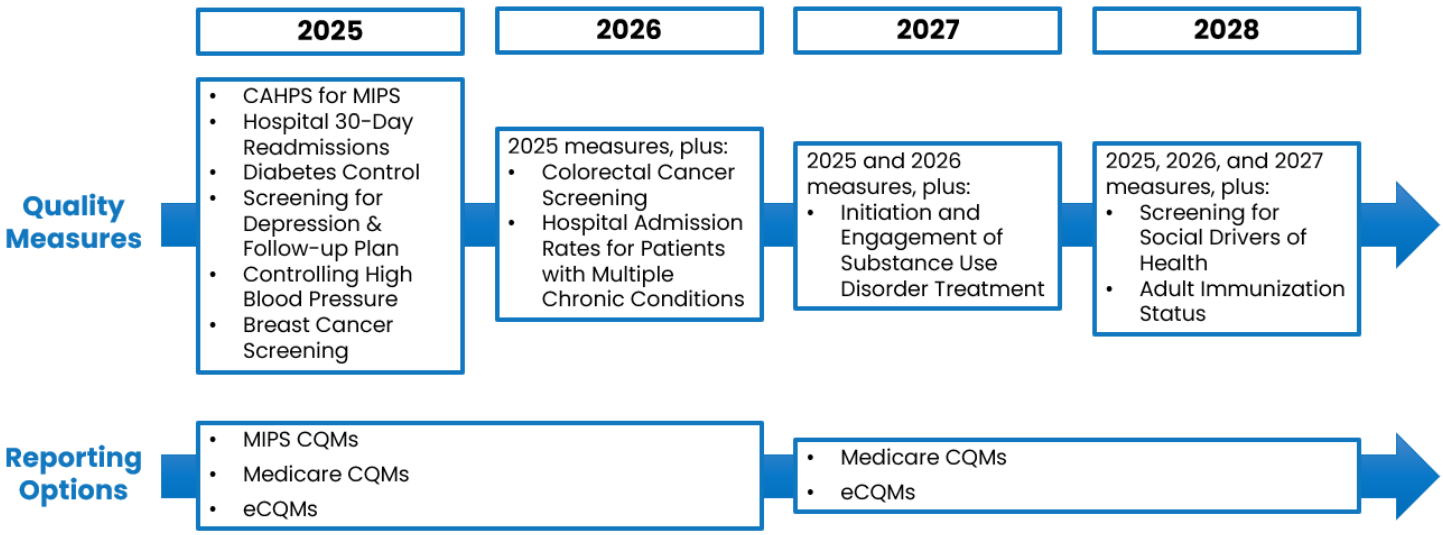
Quality Measure Reporting Mechanisms

CMS remains committed to advancing the adoption of electronic clinical quality measures (eCQMs) in the MSSP but faces challenges in doing so. In 2021, only 5 of 475 ACOs reported eCQMs and in 2022, that rose to only 24 of 482. CMS recognizes that ACOs face operational challenges transitioning to eCQM reporting and has finalized policies that will support ACOs during this transition period.

First, CMS will keep the MIPS CQM reporting option in place through 2026, rather than ending it in 2025 as proposed, following comments from ACOs indicating they had invested heavily in the infrastructure to report MIPS CQMs. The Web Interface reporting option was ended, as planned, for 2025. ACOs will now have the option to use MIPS CQMs through 2026. After this time, only eCQMs and Medicare CQMs will be available reporting mechanisms. **ACOs can report using any combination of these three options.** Notably, Medicare CQMs—which require reporting on only Medicare patients—are intended only as a temporarily-available transitional step to eCQMs, which require all-payer, all-patient reporting and align with CMS' Digital Quality Measurement (dQM) Strategic Roadmap.

CMS is also extending and adding incentives to report eCQMs. First, the agency is extending the eCQM reporting incentive, which reduces the minimum quality performance necessary to achieve the maximum savings rate and avoid the maximum shared loss rate, in the case of two-sided risk tracks. To qualify, ACOs must report *all* quality measures using eCQMs or MIPS CQMs (i.e., no Medicare CQMs). Second, CMS is adding a Complex Organization Adjustment beginning in 2025 for MIPS Virtual Groups and APM entities, including MSSP ACOs, reporting all eCQMs. The adjustment would give one extra measure achievement point for each submitted eCQM that meets data completeness and case minimum requirements, not to exceed 10% of the total measure achievement points available in the MIPS quality performance category. The adjustment would be added for each measure submitted.

Figure 3: APP Plus Quality Measure Set and Reporting Options Timeline



Beneficiary Assignment and Notification Changes

The changes made the beneficiary assignment and notification in the 2025 final rule include additional flexibility for small ACOs to encourage retention, **boosting** MSSP beneficiary assignment **with new codes** while also **encouraging assignment to disease-specific models** where appropriate, and **easing the burden of required** beneficiary notification updates.

Eligibility Requirements for Small ACOs	Beneficiary Assignment Updates	Required Beneficiary Notification Updates
Adding additional flexibilities for ACOs that fall below the minimum 5,000-beneficiary threshold during a participation agreement.	Adding new primary care codes that contribute the beneficiary assignment and updating MSSP's voluntary alignment policy to encourage alignment to disease-specific models, where appropriate.	Easing the burden of beneficiary notifications by changing the timing and scope of required follow-up notifications.

Eligibility Requirements for Small ACOs

MSSP ACOs have, by statute, been required to maintain a minimum of 5,000 aligned beneficiaries to participate in the program. This minimum threshold is intended to provide a sufficient size to ensure that any observed changes in spending are due to the impact of the ACO and not random variation, and to protect ACOs by requiring a credible population for risk. However, in the CY 2019 final rule, CMS adopted a flexible minimum savings rate (MSR)/minimum loss rate (MLR) that adjusts the MSR/MLR an ACO must achieve to earn savings/owe losses based on the number of beneficiaries assigned to the ACO. This policy, like the minimum beneficiary threshold, is designed to ensure that observed savings or losses are due to the impact of the ACO.

Prior to the changes introduced in the 2025 final rule, ACOs dropping below the 5,000-beneficiary minimum threshold during the performance year would receive a warning and corrective action plan from CMS and be terminated from the MSSP if failing to reach the minimum by the end of a performance year. Because of the flexible MSR/MLR policy, **CMS is permitting additional flexibility for ACOs. While CMS may still require corrective action plans to small ACOs working to return to the 5,000 minimum,** the termination requirement will be sunset**.** As always, ACOs will still be required to have 5,000 beneficiaries to begin a new agreement period. The number of ACOs impacted by this change will be low; between 2020 and 2023, only 24 ACOs fell below this threshold and 40% of this group were able to rise above the minimum prior to the end of the performance year and remain in the program. **CMS believes that more ACOs would be able to maintain participation given additional time to increase beneficiary assignment.**

Beneficiary Assignment Updates

CMS is making two changes, effective January 1, 2025, that will impact beneficiary assignment (also referred to as alignment or attribution).

1. To help boost the number of beneficiaries aligned to ACOs, CMS is updating the list of primary care codes used in beneficiary assignment. This includes the addition of new codes* introduced in the 2025 MPFS as well as existing codes proposed for inclusion by ACOs to CMS. (*See New High-Value FFS Coding Updates section below for more information on the new 2025 codes.)*
2. Conversely, CMS is also making a change that may decrease MSSP assignment. The agency is creating a limited exception to the MSSP's voluntary alignment policy, which currently prioritizes voluntary alignment over claims-based alignment in attribution hierarchies. Beginning 2025, claims-based assignment for a disease- or condition-specific accountable care CMMI model (e.g., Kidney Care Choices) will take precedence over MSSP voluntary alignment. This is because the agency believes that beneficiaries who qualify for these models are better served by the tailored nature of the disease- or condition-specific model designed for their care. This is expected to have only a small impact—as of 2024, less than one percent of voluntarily aligned beneficiaries would be shifted to another model. If CMMI introduces additional specialty accountable care models in the future, the impact of this change may grow *(see Implications below).*

New codes to be used for beneficiary assignment to MSSP ACOs:

- Safety Planning Interventions*
- Post-Discharge Telephonic Follow-up Contacts Intervention
- Virtual Check-in Service
- Advanced Primary Care Management Services*
- Cardiovascular Risk Assessment and Risk Management*
- Interprofessional Consultation
- Direct Care Caregiver Training Services*
- Individual Behavior Management/Modification Caregiver Training Services*

Required Beneficiary Notification Updates

ACOs are required to notify aligned beneficiaries about their participation in the MSSP, educating them on the aims of accountable care, informing them of their ability to select a provider for the purposes of voluntary alignment, and offering the beneficiary the ability to opt-out of data sharing. Effective January 1, 2025, CMS is making two changes to beneficiary notification requirements that are intended to ease the administrative burden on ACOs.

1. In 2023, CMS added a requirement that ACOs follow-up with beneficiaries after the initial notification letter, citing the opportunity for additional ACO-beneficiary engagement about the benefits of ACO alignment for the patient. Prior to the 2025 final rule, this communication was required to occur at the time of the next primary care service following initial notification or within 180 days, whichever occurred sooner. ACOs provided feedback saying that meeting this requirement was often challenging, as it is difficult to predict when a beneficiary will receive that primary care service. In addition, the service can occur very soon after the initial notification, limiting the benefit on ongoing engagement with the patient. In response to these concerns, CMS is now only requiring that ACOs provide the follow-up beneficiary communication within 180 days of when the original notification was provided, regardless of the date of occurrence of the next primary care service.
2. Additionally, for ACOs that select preliminary prospective assignment with retrospective reconciliation, CMS is limiting the number of required notifications. Prior to 2025, these ACOs were required to send notices to ***all*** Traditional Medicare beneficiaries, even if ineligible to be assigned to the ACO. Going forward, CMS will only require that notifications be sent to beneficiaries that are *likely* to be assigned to the ACO.

Other Notable VBC-Related Provisions to Know

In addition to the provisions impacting the MSSP, CMS also made minor adjustments to the Quality Payment Program (QPP)—introduced under MACRA and includes the Merit-based Incentive Payment System (MIPS) and Advanced APMs—including adding new reporting measures and establishing data submission criteria.

Additionally, other FFS-related provisions in the 2025 rule demonstrate CMS' ongoing commitment to increasing value-based care in the fee-for-service payment system by providing reimbursement for high-value services, like advanced primary care management, caregiver trainings, and digital mental health technologies, to enable providers to deliver this care regardless of their participation in an alternative payment model.

Key Changes to the QPP

CMS finalized the addition of seven new quality measures **and the removal of ten existing measures** for the Traditional MIPS 2025 performance period, also adding six new episode-based cost measures including five focused on chronic conditions.

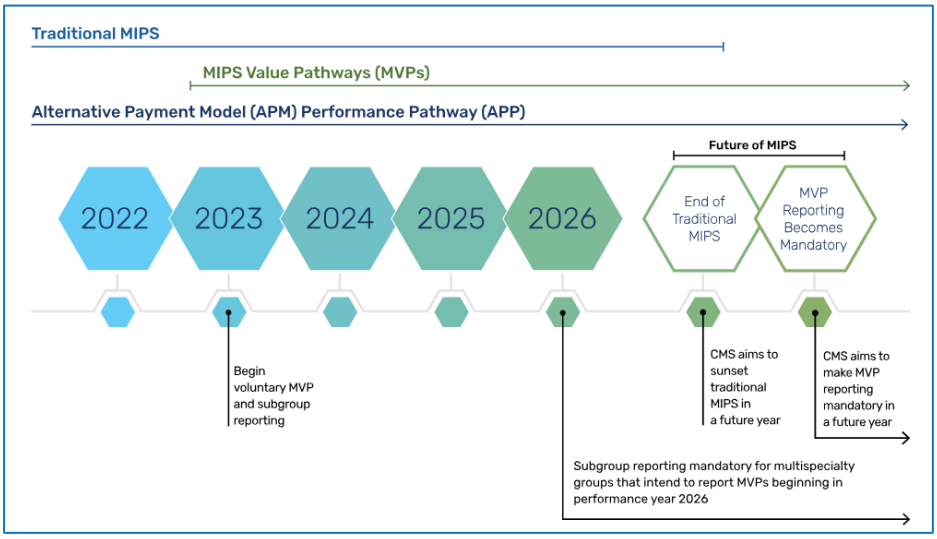
Table 3: New Quality & Cost Measures Available for Traditional MIPS 2025 Performance Period

New Quality Measures	New Cost Measures
• #494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Clinician Level) • #506 Positive PD-L1Biomarker Expression Test Result Prior to First Line Immune Checkpoint Inhibitor Therapy • #507 Appropriate Germline Testing for Ovarian Cancer Patients • #508 Adult COVID-19 Vaccination Status • #509 Melanoma: Tracking and Evaluation of Recurrence • #510 First-Year Standardized Waitlist Ratio (FYSWR) • #511 Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)	• Chronic Kidney Disease (Chronic condition) • End-Stage Renal Disease (Chronic condition) • Kidney Transplant Management (Chronic condition) • Prostate Cancer (Chronic condition) • Rheumatoid Arthritis (Chronic condition) • Respiratory Infection Hospitalization (Acute inpatient medical condition)

In addition to new Traditional MIPS measures, **CMS** added six new MIPS Value Pathways (MVPs)—the newest reporting option to fulfill MIPS requirements—**for 2025**: **ophthalmology**, **dermatology**, **gastroenterology**, **pulmonology**, **urology**, and **surgical care**. Although there is no official sunset date for traditional MIPS, CMS still plans to transition to mandatory MVP reporting *(see Figure 4)*.

CMS also made changes to data submission policies, including the treatment of multiple data submissions and the minimum criteria for a qualifying data submission. CMS also finalized a rule that **data submissions in the Quality Performance category must include numerator and denominator data for at least one quality measure** to be assigned a quality performance score. This prevents unintentional submissions without data that are assigned a score of zero, and together these provisions will improve scoring accuracy. Other aspects of the program, such as the MIPS Performance Threshold and the Data Completeness Criteria, will remain unchanged.

Figure 4: Transition from Traditional MIPS to MVPs



New High-Value FFS Coding Updates

In recent years, CMS has introduced new codes that add FFS reimbursement for services that support beneficiaries' holistic care needs to reward providers for delivering high-value care, regardless of their participation in an ACO or other value-based payment model. For example, in 2023, CMS introduced payment for Chronic Pain management and Treatment Services (CPM), designed to encourage providers to address chronic pain more holistically. In 2024, after years of delay, CMS finalized payment for a new Visit Complexity add-on code for E/M services and for Community Health Integration (CHI) and Principal Illness Navigation (PIN) services that facilitate addressing patients' health-related social needs. **CMS continues this trend in the CY25 final rule**.

To improve coding opportunities for care management[1] in primary care, CMS is finalizing the new Advanced Primary Care Management (APCM) services, represented by three new HCPCS codes (i.e., G0556, G0557, and G0558). This new code set **bundles elements of existing care management codes** and communication-technology services to reflect essential elements of advanced primary care. The billing codes are stratified by the number of chronic conditions and status as a Qualified Medicare Beneficiary to compensate providers caring for more medically complex patients. The APCM codes are a **step forward in incorporating the principles of value-based payment in a fee-for-service setting.**

Incorporating lessons from the Million Hearts Model, CMS finalized payments for Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment and risk management services, which will be performed in conjunction with E/M services for patients with an identified risk of developing cardiovascular disease. The risk assessment tool will incorporate demographic data (e.g., age, sex), modifiable risk factors (e.g., blood pressure and cholesterol control, smoking status/history), possible risk enhancers (e.g., pre-eclampsia), and laboratory data.

[1] Note: CMS also made a relatively minor change to billing for care management services in the federally qualified health center (FQHC) and rural health clinic (RHC) settings. Although FQHCs and RHCs currently use bundled billing for care management services, CMS will soon require them to bill each service individually. This change, effective in June 2025, may increase administrative burden but will improve tracking of services provided.

The newly introduced Caregiver Training Services (CTS) codes provide reimbursement opportunities for provider **time spent training caregivers to provide direct care services**. Various provider types, including medical and behavioral health clinicians, will be compensated for supporting beneficiaries' caregivers in developing essential clinical skills like wound dressing changes and infection control. Providers may also be reimbursed for assessing caregiver skills, to ensure they are well-equipped to handle patient needs. CMS expects the implications of these new codes on beneficiary health are substantial, as caregivers with basic clinical skills may improve health outcomes and reduce rehospitalizations.

Finally, CMS finalized several proposals that will impact **reimbursement for behavioral health services**, including 1. coverage for digital mental health services, 2. interprofessional consults, and 3. safety planning for patients in crisis. First, starting in January 2025, CMS will reimburse for FDA-cleared digital mental health treatment devices through three billing codes structured similarly to existing remote patient monitoring (RPM) codes. Second, expanding on the currently available interprofessional consult billing codes, CMS is adding six new interprofessional consult codes allowing eligible behavioral health providers (e.g., clinical psychologists and clinical social workers) to receive reimbursement for providing or requesting a consult. Previously, only eligible E/M providers could receive payment. Third, CMS will pay for safety planning in 20-minute increments and monthly follow-up for crisis patients discharged from the emergency department. Together, these new billing opportunities can support increased patient access to behavioral health services. Reimbursements for safety planning and follow-up will also provide patients with a structured support system post-discharge, contributing to improved mental health outcomes and reducing likelihood of readmission.

Implications of the Rule & Expectations for the Future

The provisions of the final rule presented a mixed bag for the industry—with a positive reception to the MSSP and coding changes tempered by the payment cut—but the potential for Congressional remedies gives some hope for short-term relief and potentially for long-term reforms. Beyond speculating about potential legislative action on Medicare payment reform, the 2025 final rule offers signals regarding CMS priorities for additional MSSP changes and potential future models.

Industry Response to the Changes

The MSSP-related provisions of the final 2025 MPFS have been generally well received by the industry, even as advocates call for further changes that would benefit ACOs. NAACOs—the largest ACO membership organization—applauded the changes, but is asking for CMS to do more to address the "ratchet effect," where ACO benchmarks are reduced over time following successful efforts to reduce spending. Notably, CMS did implement changes in the 2023 final rule that aimed to address this concern, but industry advocates are still calling for additional updates to further address ACOs' long-term sustainability in the program. NAACOs also expressed concern that—despite the changes made between the proposed and final rules aimed at smoothing the transition to eCQMs—ACOs are not ready to make the change. This concern was shared by the Health Care Transformation Task Force (HCTTF), who had also called for several other changes to the quality performance proposals that CMS did ultimately adopt, including a delayed implementation for some of the measures in the new APP Plus quality measure set and the retention of MIPS CQM reporting. HCTTF also requested changes that CMS did not accept, such as more flexibility on how prepaid shared savings can be used and an expansion of the types of beneficiaries eligible for the HEBA.

Other aspects of the rule have been met with mixed reception. There was largely a positive reaction to new "high-value FFS" codes—especially the APCM codes—which primary care advocates say represent an "important step toward achieving hybrid primary care payment within the framework of Traditional Medicare."

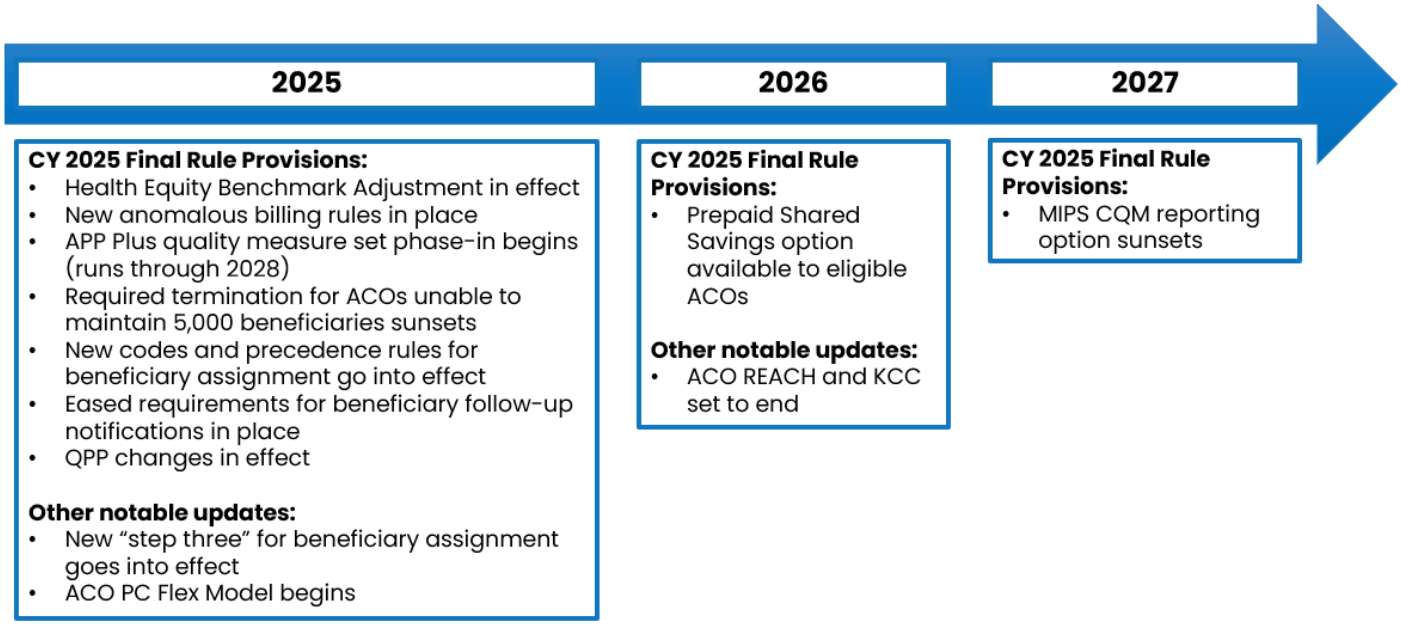
On the other hand, the industry is frustrated that CMS kept a 2.9% pay cut in place. Here though, CMS largely has its hands tied by statue, which has led to another stopgap effort, with Congress likely to pass a bill introduced at the end of October to **delay the proposed 2.8% pay cut and add an inflationary adjustment** that together would provide a 4.7% increase over the finalized MPFS rates. There are expectations, though, the Congress will act on more comprehensive Medicare physician payment reforms. A May 2024 RFI from the Senate Committee on Finance indicates that the body is thinking about **how to make the MPFS sustainable for both physicians and taxpayers**. In response to the final rule, the AMA published a response highlighting the actions it is encouraging Congress to take, including reforming budget neutrality requirements for the fee schedule, overhauling MIPS, and making more modifications to APMs. The letter also calls for **tying future payment updates to inflation**—as seen in other fee schedules like the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS)—something other stakeholders, including MedPAC, are also discussing.

Implications of the 2025 MPFS for ACOs

Consistent with the themes of the MSSP updates made by the current administration over the past few years, the 2025 changes are expected to be most beneficial to smaller and undercapitalized ACOs as well as those caring for underserved beneficiaries. The major benefits include:

1) **Prepaid shared savings** option, which will help to retain existing successful ACOs with cash flow constraints that are considering renewal in 2026 or subsequent years. This may include ACOs that might have been eligible for the ACO PC Flex Model but missed the application window, did not want to rebase their benchmarks, or were otherwise ineligible or uninterested in the primary care capitation CMMI pilot.
2) **The HEBA**, which creates opportunities for a more favorable benchmark adjustment for ACOs providing care for underserved beneficiaries without penalizing those who do not.
3) **New primary care codes for beneficiary assignment** (along with the new "step three" finalized in last year's fee schedule) both beginning in 2025 that will help to boost the number of beneficiaries assigned to ACOs.
4) **Flexibility for small ACOs to stay in the program**, even if they drop below the 5,000 minimum lives threshold. This change—together with the option to receive prepaid shared savings—may support small ACOs wishing to remain independent rather than partnering with another entity for access to capital or to aggregate lives.

While the shift to eCQMs continues to present a barrier to participation, CMS has been responsive to the industry in easing the transition timeline, and other changes are uniformly positive, even if not all ACO concerns have been fully addressed. With ACO REACH drawing to a close at the end of 2026 and no clear expectation for what comes next, these changes are likely to make the MSSP an even more attractive transition option for REACH ACOs, especially if the higher risk track contemplated in the RFI implemented into the program *(See Embedded RFIs Signal CMS Priorities below)*. A full accounting of changes can be found in the Timeline in *Figure 5* below.



Embedded RFIs Signal CMS Priorities

In the 2025 MFPS proposed rule, CMS issued several Requests for Information (RFIs) seeking stakeholder feedback on opportunities to enhance value for Medicare beneficiaries and improve coordination between providers. These RFIs provide valuable insights into CMS priorities and potential future action. For example, after soliciting feedback on the design of a potential mandatory episode-based payment model in July 2023, CMS later announced Transforming Episode-Based Accountability Model (TEAM) applying industry input and lessons from prior initiatives. The RFIs included in the 2025 fee schedule rulemaking process are summarized below.

- Higher MSSP Risk Track. In the CY 2024 MPFS proposed rule, CMS sought input on the potential addition of a higher risk track to the MSSP that would offer an opportunity to bear increased financial risk than the current ENHANCED track. According to the CY 2025 MPFS rule, the agency is now instead considering *revising* the existing ENHANCED track to incorporate higher risk rather than adding a new track. While commenters were broadly supportive of a higher risk track, they generally opposed replacing the current ENHANCED option – which is highly popular among risk-bearing participants. As of January 1, 2024, just under half of MSSP ACOs (207 of 480) were in the ENHANCED track, meaning that the contemplated changes could have a substantial impact to the program. As currently envisioned, the higher risk track would utilize many of the mechanisms seen in CMMI's ACO models like ACO REACH, including the use of a discount to the benchmark to ensure savings for CMS (though CMS is contemplating retaining the MLR for added protection for ACOs, unlike REACH), risk corridors, and potentially capitation.
- Advanced Primary Care. Complementing the new APCM billing codes, CMS issued a general Advanced Primary Care RFI to gather feedback on possible future payment policies for advanced primary care delivery. The RFI included questions on five key components: 1) streamlined value-based care opportunities; 2) billing requirements; 3) person-centered care; 4) health equity, clinical, and social risk; and 5) quality improvement and accountability. Commenters were optimistic about the future of advanced primary care, although some suggested restricting APCM billing to ACOs or total cost of care models. This feedback will be essential to CMS as it continues to emphasize accountable care and transition beneficiaries into accountable care relationships.

- **Ambulatory Specialty Model.** Also of note, CMS released an RFI on how to **build on the specialty-focused MVPs framework to improve ambulatory care**. CMS may use RFI responses to develop an ambulatory specialty model designed to improve quality and coordination of specialty care delivered in outpatient settings. In this potential model, participants would receive a payment adjustment based on performance on clinically-relevant MVP measures, assessed compared to other participants within the same specialty and with similar clinical populations. Providers would then receive more relevant feedback reflecting their performance compared to peers rather than a general pool of providers. CMS hopes that this would increase specialist engagement in value-based care initiatives – a priority focus area for CMS and its Innovation Center.
- **SDOH Services & Community Collaboration.** Finally, CMS also seeks to continue address social determinants of health and advance health equity by requesting information on services to address health-related social needs. In 2024, CMS established reimbursement for a variety of services to address beneficiary social needs including community health integration, principal illness navigation, and social determinants of health risk assessment services. CMS was particularly interested in learning more about how providers collaborate with community-based organizations to provide these services. These comments may provide guidance for reimbursement for other services addressing patient social needs, and reflect CMS' ongoing commitment to comprehensive, value-driven care.

As Medicare's largest, permanent ACO program, the MSSP will remain the focus of CMS, even as CMMI continues piloting new models and as the agency continues to incorporate value-based principles into the FFS payment system. As illustrated by the RFI requesting input of the addition of a full risk track and the incorporation of program changes like AIPs and prepaid shared savings, lessons from CMMI models continue to work their way into the MSSP, providing a solid foundation for CMS' continued efforts in transitioning the industry to value-based care.

While a new administration will be taking the reins at CMS in 2025, bipartisan support for the MSSP means that many—though perhaps not all—of the changes made over the past few years are likely to remain in place and the priority of driving growth in accountable care programs will continue to be a key component of Medicare's broader strategy for slowing cost growth and improving quality, regardless of the political party in office.