TMA Top 10:
What Physicians Need to Know

Travis County Medical Society
Sept. 23, 2025

Kim Harmon, AVP, Innovative Practice Models
Texas Medical Association
kim.harmon@texmed.org • (512) 378-0051

CME Objectives

Upon completion of this program, participants should be able to:

- Describe key changes to the 2025 Medicare Physician Fee Schedule as related to payment and coverage policies; and
- Discuss how updates impact quality payment programs, shared savings programs, and telehealth.

The TMA designates this educational activity for a maximum of 1 *AMA PRA Category 1 credit*™. Physicians should only claim credit commensurate with the extent of their participation in this activity. This activity has been designated as 1 hour of ethics and/or professional responsibility education.

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Federal Environmental Scan

- Make America Healthy Again – chronic disease, environmental, and preventive health
- Lowering health care costs and price transparency
- Reducing ***federal*** health care spending and budget cuts
- Restructuring HHS and streamlining bureaucracy

Major HHS Restructuring

New/Modifications to CMMI Models

Medicaid/CHIP: cost shifting

Vaccine Program

Medicare Advantage Transparency

Fraud, Waste, and Abuse

ACA Enhanced Tax Credits

Unified Agenda: Health Care

- On September 4, 2025, the Trump Administration released the Spring 2025 Unified Agenda of Regulatory and Deregulatory Actions.
- Published twice a year, the Unified Agenda is a government-wide publication of rulemaking actions agencies are currently working on and expect to take in the coming months.
  - Regulatory actions (i.e., new regulations)
  - Deregulatory actions (i.e., reductions in or elimination of current regulations).
  - Regulations that have been withdrawn since the most recent edition of the Unified Agenda—e.g., rules that the Biden Administration had been working on in late 2024, but the second Trump Administration no longer appears to be pursuing.

https://www.congress.gov/crs_external_products/IN/PDF/IN12605/IN12605.3.pdf

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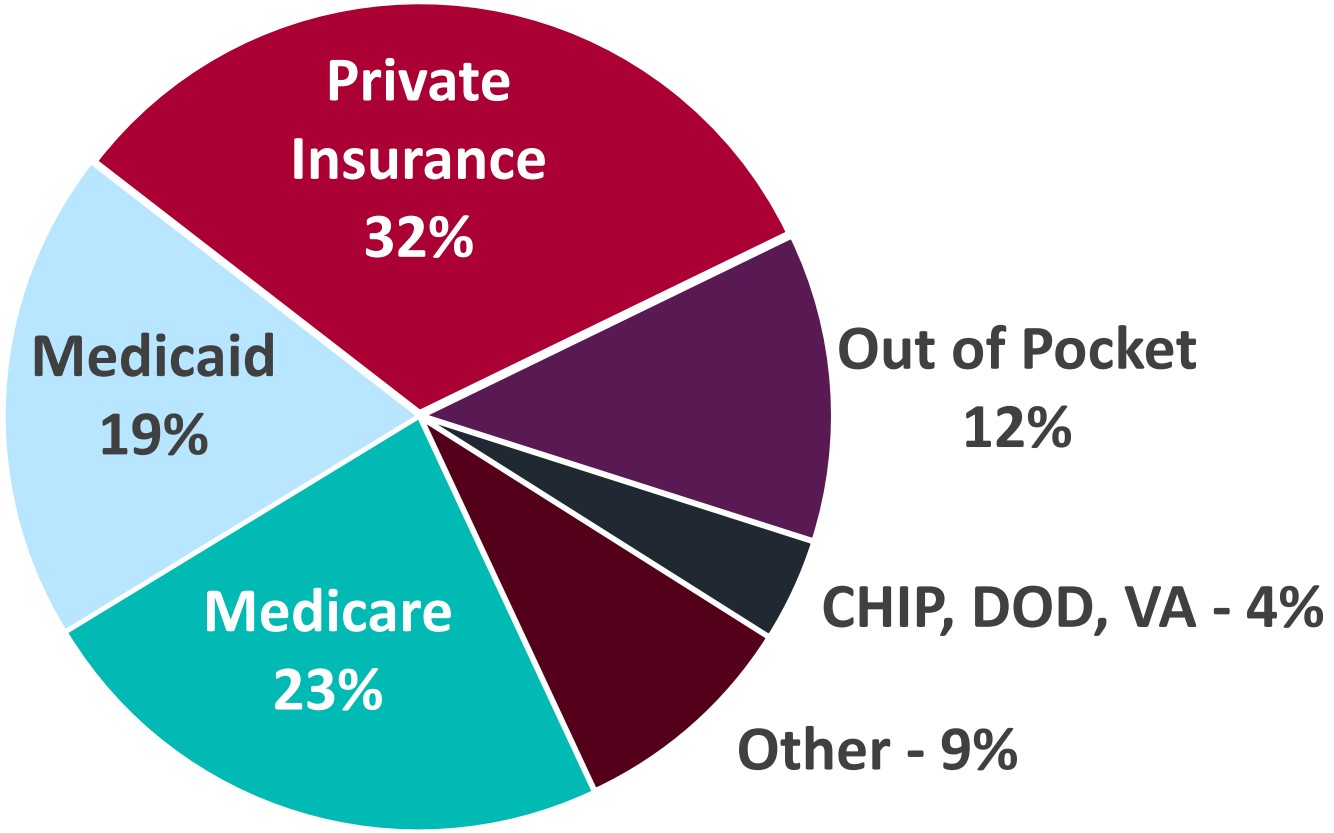
Health Care Purchasers: 2023

Total = $4.1 trillion

Federal government is responsible for 50% of the spend



Health Care Spending and the Medicare Program, MedPAC, July 2025

www.medpac.gov

July 2025 Data Book: Health Care Spending and the Medicare Program

- With 60.7 beneficiaries, Medicare is the largest single purchaser of personal care in the U.S with a $956 billion spend on direct patient care in 2023
- **Spending is expected to double in the next 10 years when it will reach an estimated $2 trillion**
- By 2030, all baby boomers will reach the Medicare eligibility age.
- In 2023, the average annual Medicare spending per beneficiary was $16,698.

Medicare Payment Basics

1. **Relative Value Units (RVUs)**
   - **Work** reflects the relative time and intensity associated with furnishing a service
   - **Practice Expense** reflects practice costs (direct and indirect)
   - **Malpractice** reflects the costs of malpractice insurance

2. **Geographic Practice Cost Indices (GPCIs)**
   - Medicare adjusts each RVU to account for geographic variations in practice costs across the U.S.
   - There are 8 geographical areas in Texas (Brazoria, Dallas, Galveston, Houston, Jefferson, Tarrant, Travis, Other)

3. **Conversion Factor (CF)**
   The sum of the geographically adjusted RVUs are multiplied by a CF in dollars. Statue specifies the formula by which the CF is updated annually

Budget Neutrality

- Under Section 1848 of the Social Security Act, CMS must keep total Medicare spending on physician services budget neutral when changes in relative value units (RVUs) would increase spending by more than **$20 million** in a year.
- If CMS increases payment for one set of services, it must decrease payments elsewhere so that the overall pool of money stays the same.
- Congress sometimes intervenes with short-term fixes (e.g., adding temporary 2–3% bumps) to soften cuts, but those are not permanent solutions.

2025 Medicare Physician Fee Schedule

- The 2025 final Medicare conversion factor is $32.35; a **2.83% payment decrease** compared to 2024.
- This is the 5th consecutive year of physician payment cuts with AMA calculating 33% decline in inflation-adjusted payments from 2001-2025.
- Medicare payments have been reduced by 22 percent since 2001, when adjusted for inflations in practice costs.
- The Medical Economic Index (MEI), a cumulative measure of the individual costs of running a practice will increase by 3.5% this year.

Conversion Factor Decrease from Previous Year

2025: 2.83% decrease
2024: 3.37% decrease/1.68%
2023: 2.08% decrease
2022: .082% decrease
2021: 3.32% decrease

Medicare Advisory Payment Commission Recommendations

- Replace the current Medicare fee-for-service physician fee schedule with an annual update based on a portion of the growth in inflation, as measured by the Medicare Economic Index.
- Improve the relative accuracy of physician fee schedule by collecting and using timely data that better reflect the relative costs of delivering care.
- We expect that these recommendations would increase federal program spending by between **$15-$30 billion over five years** relative to current law. (assumes a 2.2% increase per year)

Medicare and the Health Care Delivery System, MedPAC, June 2025

Proposed: 2026 MPFS
Temporary Relief, But No Lasting Solution

- For the first time, in six years, CMS proposed in increase to physician payments. There are multiple conversion factors:
  - $33.4209: General (3.3% increase)
  - $33.5875: Advance Practice Models (3.8% increase)
- Calculations include:
  - Temporary, one-year 2.5% update from OBBBA.
  - Positive budget neutrality adjustment of 0.55% (proposed cuts elsewhere)
  - A statutory update from Medicare Access and CHIP Reauthorization Act (2015) for 0.7% for qualifying APM participants and 0.25% for all other clinicians.

Proposed: 2026 MPFS:
Unsustainable Cuts on Top of Eroding Payments

- CMS has relied on the AMA Physician Practice Information Survey (PPIS) dataset for 15 years of payment rules.
- CMS proposed to not use AMA's PPIS data for the 2026 practice expense update and will instead maintain existing PE per hour data, cost share values, and methodology from prior years.
- While CMS cites concerns with low survey response rates, representativeness, and data completeness, the agency acknowledges that the PPIS remains the most comprehensive source of PE information available.
- Despite not keeping up with inflation, CMS proposes new cuts that further weaken physician practices.

2026 MPFS: Efficiency Adjustment

- CMS proposes a new efficiency adjustment of -2.5% applied to the intraservice portion of work RVUs for services that are not time-based such as diagnostics and surgical or procedural services.
- The adjustment includes code families representing almost 9,000 non-time-based physician services. CMS asserts that clinicians become more efficient over time with changes in clinician expertise, workflows, and technology.
- The adjustment would be updated and reapplied every three years.

Fraud, Waste, and Abuse

2026 MPFS: Indirect Practice Expense

- For CY 2026, CMS proposes to reduce the portion of PE RVUs based on work RVUs in a facility setting by 50% of what is allocated in a non-facility setting.

- CMS argues that over time more physicians have been employed by hospitals/health systems rather than operating independent practices. These physicians may no longer carry the overhead costs that independent physician-owned practices do.

Fraud, Waste, and Abuse

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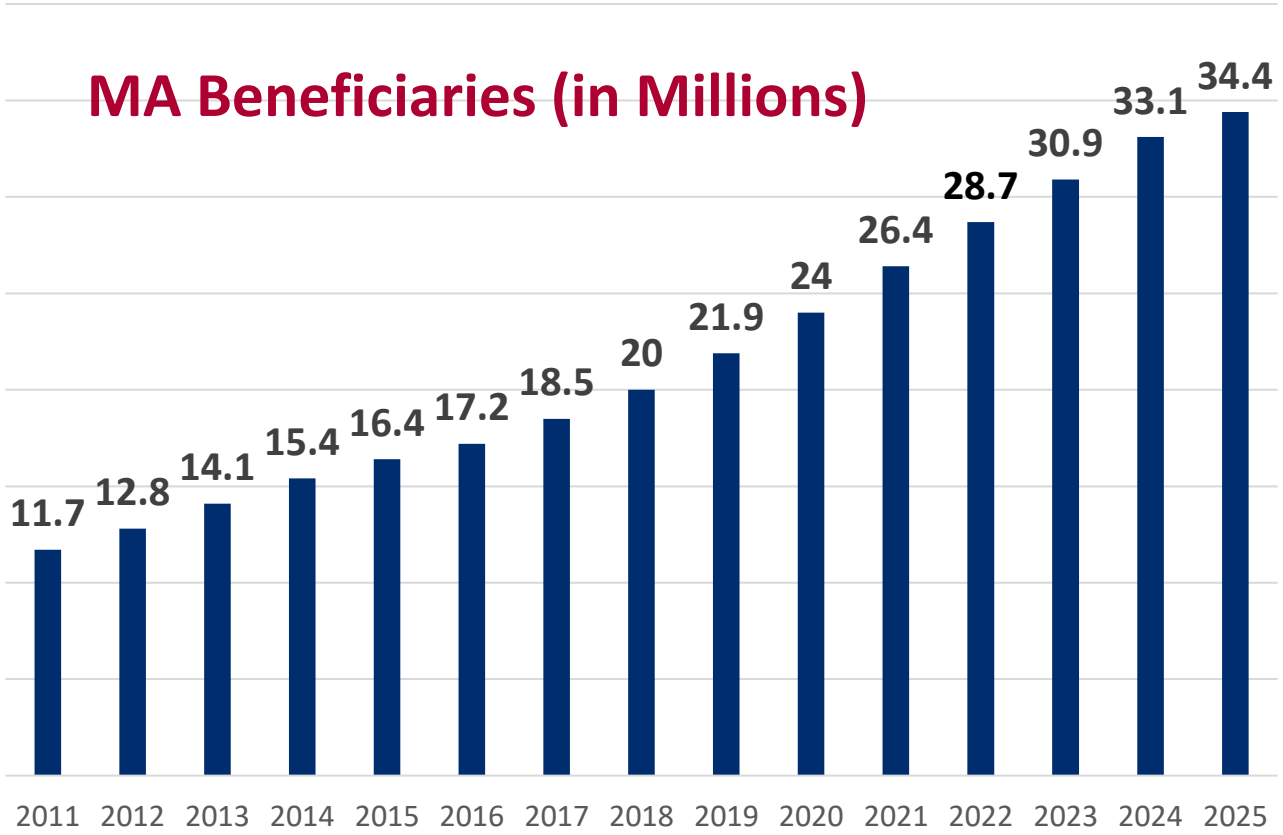
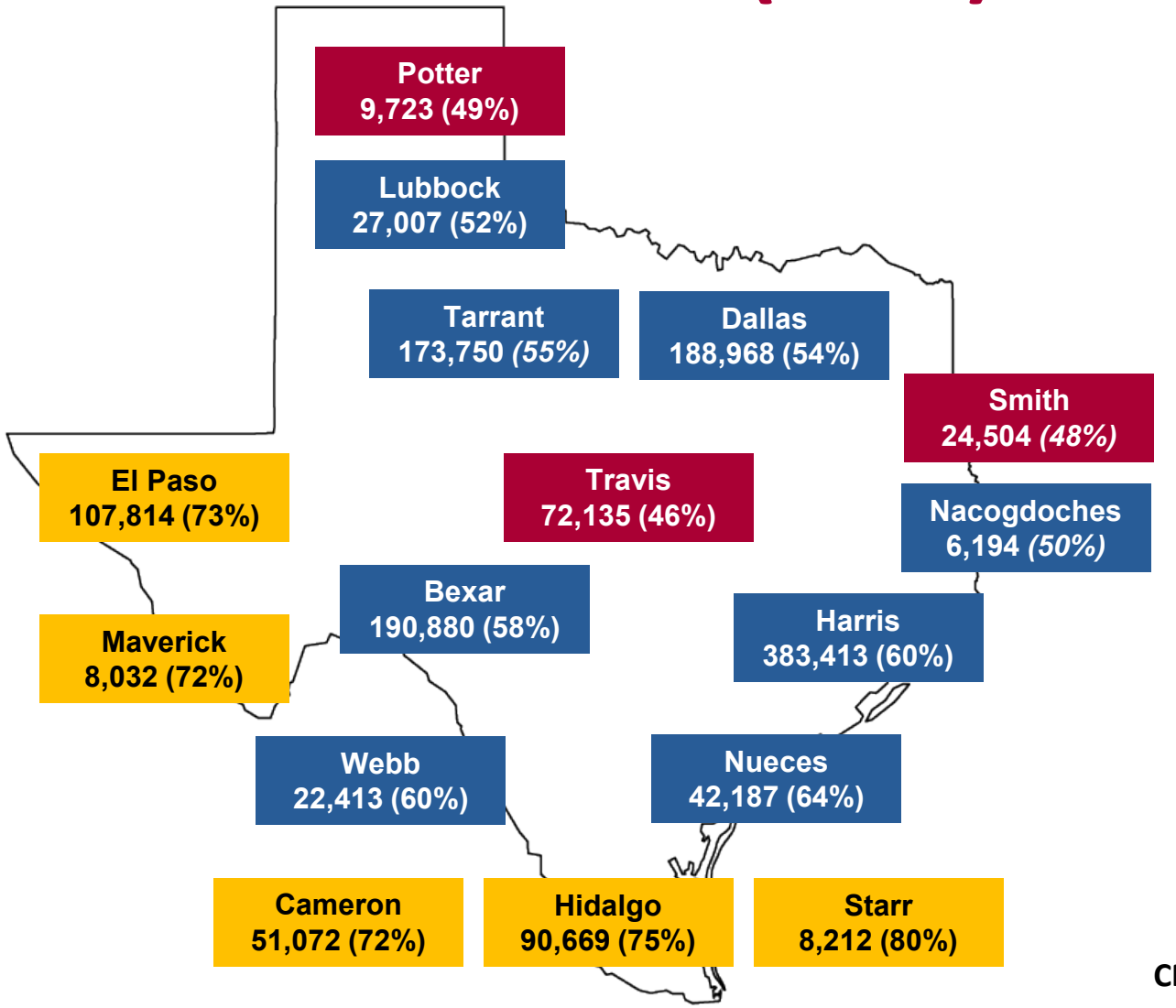
Medicare Advantage Enrollment

- **Roughly 55% of all eligible Medicare beneficiaries are enrolled in MA.**
- MA is growing at a faster pace than FFS (traditional) Medicare
- MedPAC estimates that MA plans are responsible for 20% more spending than similar beneficiaries in traditional Medicare.



MedPAC Data Book: Health Care Spending and the Medicare Program, July 2025

Texas MA Penetration (59%)



Open enrollment is Oct. 15 – Dec. 7

CMS.gov: MA State/County Penetration – Dec. 2024

MA Concerns: Privatization of Medicare

Health Plan	2024 Market Share
United Healthcare	9.9M (29%)
Humana Inc.	5.7M (17%)
BCBS Plans	4.6M (14%)
CVS Health/Aetna	4.1M (12%)
Elevance Health Inc.	2.2M (7%
Kaiser Foundation	2 M (6%)
All others	10.3M (30%)

Nationwide, United Healthcare and Humana account for 46% of all MA enrollees

KFF Analysis of CMS Medicare Enrollment files, 2025

A Tough Few Years for MA Health Plans

- Patient utilization significantly up after COVID
- New risk adjustment model and changes to Star ratings – more challenging to earn bonus payments
- OIG scrutiny with audits on risk adjustment/documentation
- 2026 Plan Year Changes – how will Trump Administration respond?
- Guardrails on marketing and use of brokers
- ~~Addition of health equity requirements~~

Trump Administrative Likely Priorities

- Identification of fraud, waste, and abuse
- Scrutiny of home risk assessments
- CMS return on investment for supplement benefits
- Drug pricing
- Prior Authorization
- Continued scrutiny of risk adjustment methods

Fraud, Waste, and Abuse

Health Management Associates: Medicare Town Hall: April 30, 2025

Risk Adjustment Validation Audits

On May 21, 2025, CMS announced a significant expansion of its auditing efforts for Medicare Advantage plans. Beginning immediately, CMS will audit all eligible MA contracts for each payment year in all newly initiated audits and invest additional resources to expedite the completion of audits for payment years 2018 through 2024.

What you need to know:

- Expect more audits from health plans
- Review contracts/provider agreements for clauses related to audit liability or clawbacks and due process rights in the event of a dispute.
- Remember YOU are ultimately responsible for coding and documentation.

Fraud, Waste, and Abuse

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Medicaid Spending

- Children account for a third of enrollees, but only **14%** of spending.
- Low-income adults 65 years and older and people with disabilities make up about a quarter of Medicaid enrollees but account for more than **50%** of total Medicaid spending, because of high health needs.
- Medicaid covers nearly 20% of adults and 40% of children in rural areas, according to the National Rural Health Association.

Medicaid/CHIP Coverage In Texas

- **19% of Texans**
- **43% of Texas children**
- **53% of Texas births**
- **56% of Nursing home residents**

Medicaid Financing: The Basics: KFF, 1/29/25

Medicaid Funding

- Medicaid is jointly funded by states and the federal government through a federal match program known as the federal medical assistance percentage, or FMAP.
- The federal government provides a FMAP of at least 50% to states and may not exceed 83%. **Texas currently receives about 59.8% in matching funds**.
- This rate goes up for states with lower per capita income. According to KFF, Mississippi received the highest match rate of 77% for the 2026 federal fiscal year.
- **For Medicaid expansion states, the government pays 90 percent**.

Texas Medicaid: Physician Revalidation

Following TMA advocacy regarding flaws with the state's Medicaid Provider Enrollment and Management system (PEMS) used for Texas Medicaid:

- The Health and Human Services Commission (HHSC) issued a 180-day revalidation extension for physicians with deadlines between Dec. 13, 2024, and May 31, 2025. This has been extended through Nov. 30, 2025.
- HHSC also agreed to make adjustments for physicians who were disenrolled for failing to revalidate between Nov. 1, 2023 - Dec. 12, 2024 by backdating the enrollment period by 365 days to address the gap in enrollment.
- Call TMA if you are having issues!

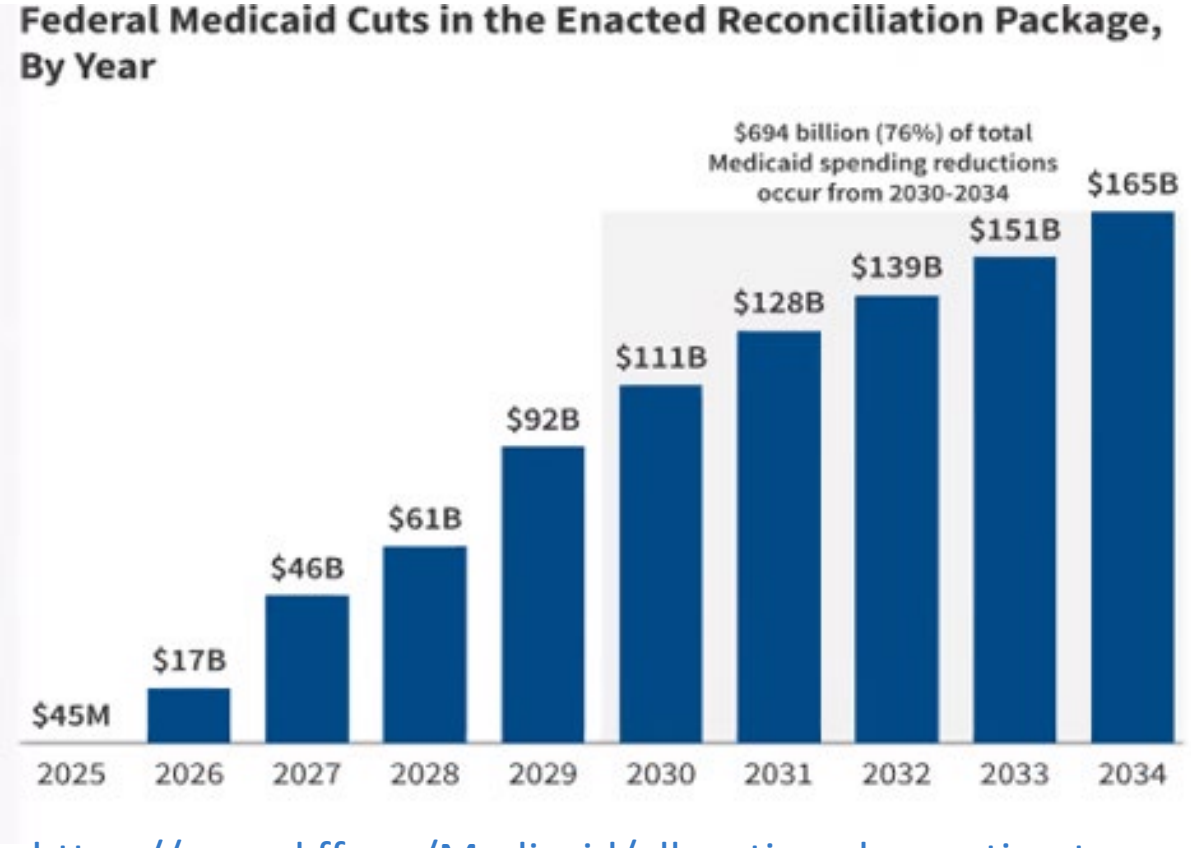
Texas Medicaid/CHIP Contracting

STAR/CHIP: Primarily for pregnant women, low-income children, and some adults who can't afford insurance.

- March 2024 "Intent to Award Contracts" with effective date of Sept. 1, 2025
- 1.8 million Texans would be shifted to new insurers if the decisions stands
- Left out plans run by legacy children's hospitals – Cook Children's (Fort Worth), Children's Hospital (Houston) and Driscoll Children's Hospital (Corpus)
- A District Judge in Travis County blocked HHSC from finalizing the contracts in Oct. 2024 and a trial to determine if a permanent restraining order will be issued is scheduled for **Nov. 3, 2025**

One Big Beautiful Bill Act (H.R. 1)

- Enacted July 4, 2025
- The U.S. Department of Health and Human Services (HHS) will review the legislation and start developing an implementation plan.
- Many health-related provisions will not take effect for years.
- There will be multiple opportunities to modify or delay these policies via regulation or legislation.
- And…there **will** be lawsuits.



https://www.kff.org/Medicaid/allocating-cbos-estimates-of-federal-Medicaid-spending-reductions-across-the-state-enacted-reconciliation-package/

BBB Summary: Medicaid

Impacts vary by state, and the following does not apply to Texas:

- Medicaid work requirements for *expansion* population
- Cost sharing requirements for *expansion* population
- Provider tax reduction for *expansion* states
- State directed payment reduction for *expansion* states
- Sunsets 5% federal match increase for new *expansion* states

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BBB Summary: Medicaid

Reducing fraud and improving the enrollment process

- 7/4/25 Moratorium on Biden-era eligibility/efficiency regulations
- 1/1/27 Ensure address and eligibility verification
- 1/1/27 Ensure deceased individuals do not remain enrolled
- 1/1/28 Ensure deceased providers do not remain enrolled
- 1/1/27 Changes presumptive eligibility requirements (2 months)

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BBB Summary: Other Medicaid Issues

Provider Taxes: 7/4/25

- State-imposed taxes on providers (such as hospitals or nursing facilities) used to generate and draw down federal Medicaid matching funds.
- In non-expansion states, existing provider taxes may continue under current thresholds but cannot be altered or newly created after enactment.

State Directed Payments: 7/4/25

- Financing arrangements allowing states to require Medicaid managed care plans to pay providers using specific methodologies (often tied to Medicare or commercial benchmarks).
- New SDPs are capped at 110% of Medicare rates in non-expansion states (previously capped at commercial rates).

BBB Summary: Medicaid

1/1/26 Rural Health Transformation Program

A $50B program implemented through states over five years with $10B allocated annually from 2026 to 2030.

- Half will be equally divided among states with approved plans
- Half will be allocated according to a CMS-determined formula

States control allocations, which can be used for multiple purposes, not just funding rural hospitals

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How Do ACA Tax Credits Work?

- Premium subsidies lower the monthly cost of insurance purchased through the Health Insurance Marketplace.
- Currently available to those with household incomes 100-400% of the Federal Poverty Level (FPL), based on income, household size, and lack of other affordable coverage.
- Credit amount is tied to the cost of the 2nd-lowest Silver plan. Enrollees must pay a set percentage of their income toward premiums; the tax credit covers the rest.
- Credits can be applied in advance (monthly) or claimed later when filing federal taxes.
- IRS reconciles at tax time resulting in repayment if income is higher than projected, or a refund if lower.

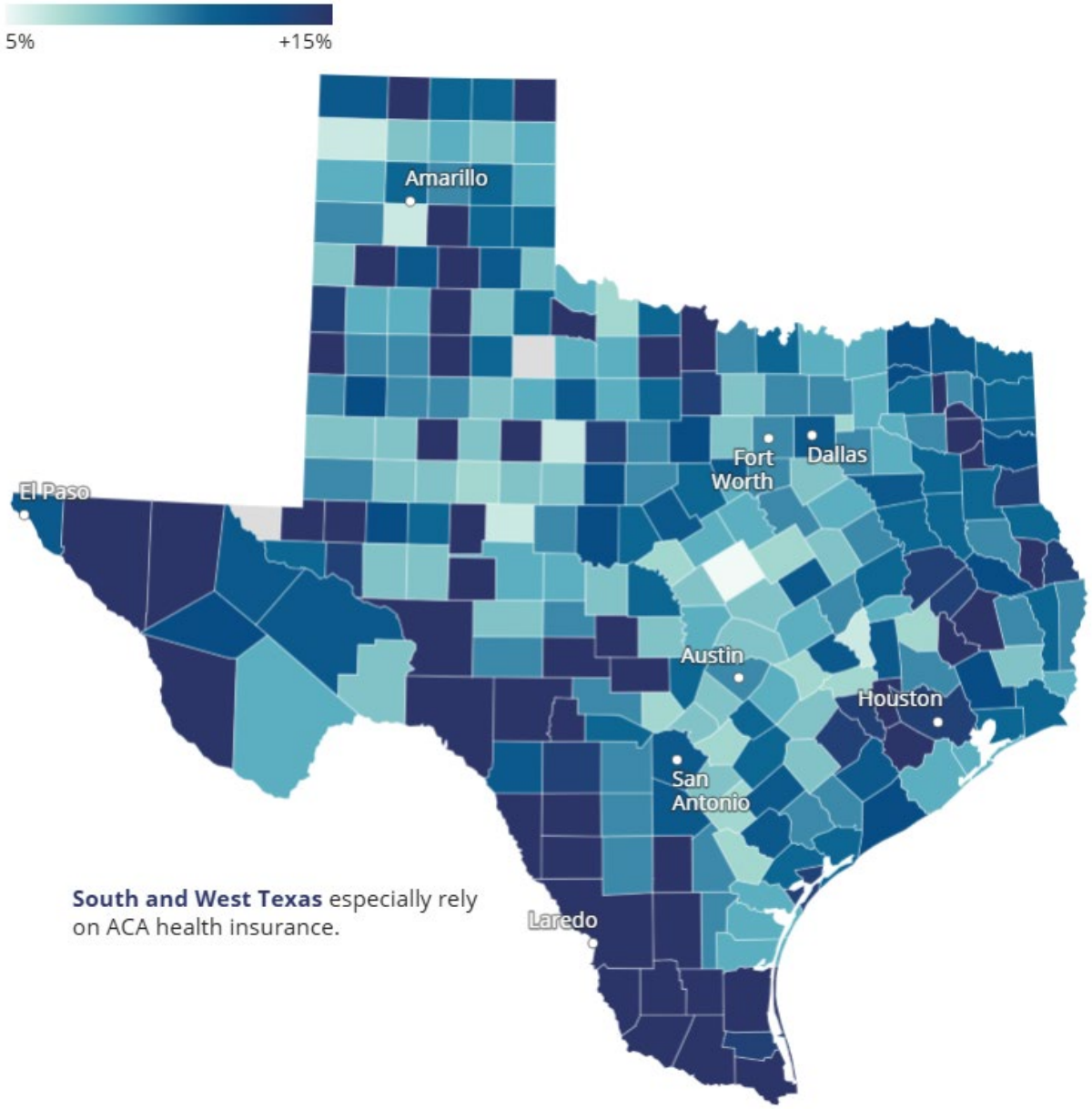
The ACA Marketplace

- Premium tax credits reduce enrollees' insurance premiums based on their projected income for the next year. They were originally available for those between 100-400% of the federal poverty limit.
- Amid the COVID-19 pandemic, the American Rescue Plan Act increased the amount of tax credits and expanded eligibility.
- **Originally set for two years, the enhanced tax credits were extended and are scheduled to expire at the end of 2025.**
- Since introduction of the enhanced tax credits, ACA marketplace enrollment has more than doubled from 11.4 million in 2020 to 24.3 million in 2025.

KFF: Marketplace Enrollment, 2014-2025

ACA Enrollment in Texas

- Nearly $4 million Texans are currently enrolled in the ACA.
- In 2024, the ACA marketplace covered more than 15% of residents in 40 Texas counties.
- KFF projects more than 1.1 million Texans could lose coverage between BBB provisions, additional CMS rules, and projected expiration of the enhanced premium tax credits.



Annual Premium Payments
for ACA Marketplace Benchmark Plan

2026 Scenario	With Enhanced Tax Credits	Without Enhanced Tax Credits	Increase
27 YO individual making $35,000 (224% of FPL)	$1,033	$2,615	$1,582 (153%)
35 YO couple making $30,000 (142% FPL)	$0	$1,107	$1,107
49 YO couple with a 19 YO child making $90,000 (338% FPL)	$6,246	$8,964	$2,718 (44%)

Premium payments are calculated using 2025 benchmark premium data with the appropriate required contribution payment caps applied. https://www.kff.org/affordable-care-act/premium-payments-if-enhanced-premium-tax-credits-expire/

BBB Summary: ACA

- 1/1/26 Repeals a special rule so that lawfully present aliens with household incomes of less than 100% of the federal poverty level (FPL) who are ineligible for Medicaid by reason of alien status are not eligible for premium tax credits.

- 1/1/28 Consumers must pre-verify their eligibility for each open enrollment period and have the Exchange clear their verifications **before** they will be eligible to receive advance premium tax credits (APTCs).

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BBB Summary: Health Savings Accounts

- 1/1/26 Any bronze or catastrophic plan offered in the individual market on the ACA Exchange will be treated as an HDHP, meaning enrollees will be HSA eligible.

- 1/1/26 Clarifies that employees with Direct Primary Care memberships can contribute their pre-tax dollars into HSAs.

- 1/1/26 Direct primary care membership fees will also be an allowable HSA expense for those who don't get a subscription through their employer. For these purposes, the arrangements cannot cost more than $150 per person/per month, adjusted annually for inflation.

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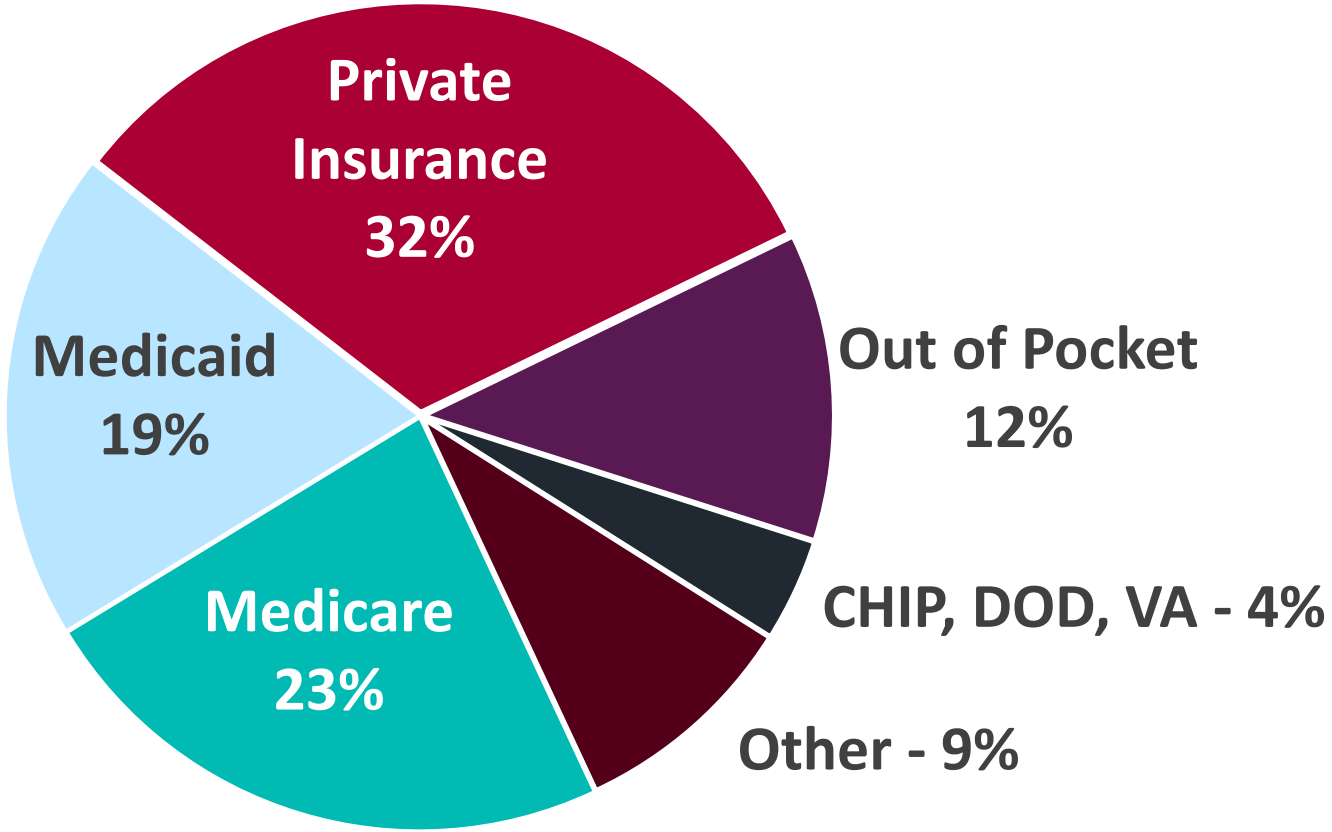
Health Care Purchasers: 2023

Total = $4.1 trillion

More than 50% of Americans are covered by private insurance



Health Care Spending and the Medicare Program, MedPAC, July 2025

2024 PPRC Dashboard

Top Five Inquiries	
Claim Denial	176
Coding	91
Prior Authorization	85
Credentialing	77
Medical Records	59

TMA recovered nearly $3.1M for Texas Practices in 2024

Average Days to Complete and Inquiry	
Molina	247
Southwest Health Resources	174
Wellpoint (Amerigroup)	115
Aetna	104
Humana	94
WellMed	67
Baylor Scott & White	57
Ambetter	50
United	46
Medicaid	34
Blue Cross and Blue Shield	33
WellCare	28
Superior	12
Medicare	11

Sample Agenda

- **Coding and Claims Issues**
  Ex: downcoding, prior authorization, medical record requests
- **Payment Policies/Coverages**
  Ex. anesthesia physical status modifiers, telemedicine
- **Service Line Discussions**
  Commercial, Medicaid, Medicare Advantage
- **Emerging Issues**
  Ex. AI strategies, cyberattack impacts, value-based care
- **Upcoming Changes, New Plans, or Programs**

Payer Meetings

Aetna

BCBS

Cigna

Humana

United

WellMed

Scott & White

Hot Topic: Downcoding

Humana: Effective April 2024
Determines the payment level based on the severity of the patient's condition. When the billed E/M service code is higher than what is supported by the claim diagnosis code, Humana adjusts reimbursement to the E/M service level determined by the review.

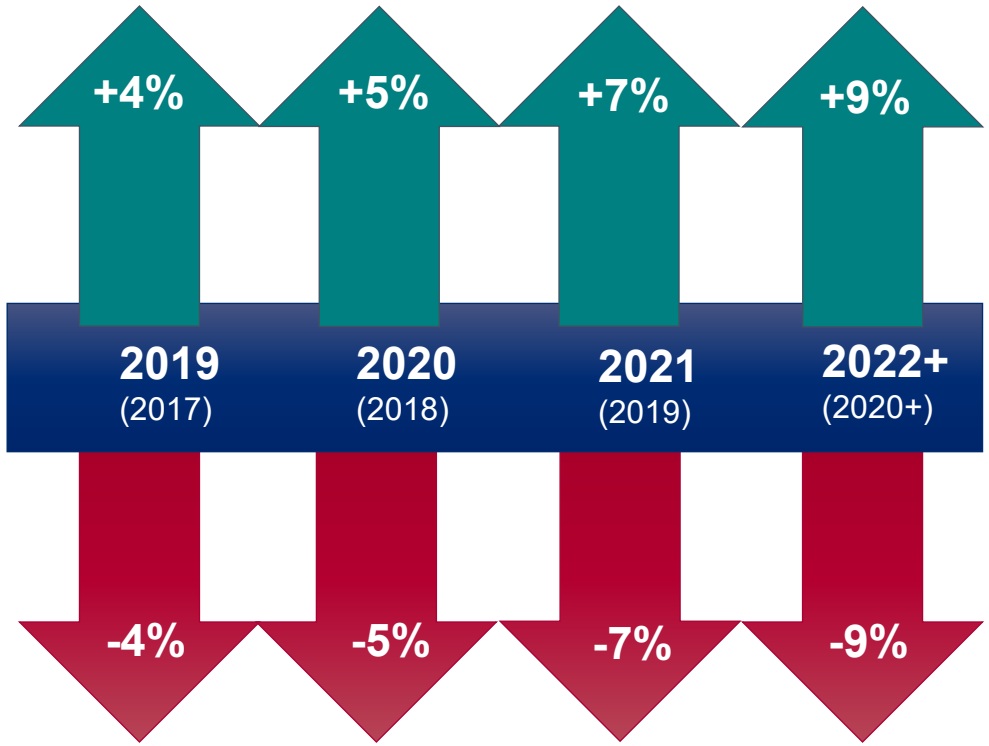
Cigna: Effective October 1, 2025
May adjust the E/M CPT® code 99204- 99205, 99214-99215, 99244-99245 to a single level lower when the encounter criteria on the claim does not support the higher-level E/M CPT® code reported. (automatic downcoding).

Aetna: Effective Jan. 1, 2025 (Medicare Advantage)
Evaluates level 4 and 5 E/M services with no mention of "recoding or downcoding"
This policy has been in effective for commercial products since 2018.

CMS Quality Payment Program (QPP)

Under the QPP, clinicians receive payment adjustments based on their performance in the Merit-based Incentive Payment System (MIPS) or as a qualifying participant in the advanced alternative payment model (APM) track.

AMA estimates cost of compliance at $12,800 per physician per year and 53 hours of work



2025 Adjustment:
+2.15% for a perfect score

CMS Quality Payment Program (QPP)

What You Need to Know:

- MIPS Value Pathways (MVPs) were introduced in 2023 as an optional alternative to MIPS.
- CMS indicates that MVPs encourage clinicians to report on a smaller, cohesive set of measures that are more relevant to their practices.
- Six new MVPs are proposed for 2026 bringing the total to 27. These include: diagnostic and interventional radiology, pathology, vascular surgery, neuropsychology, and podiatry.
- MVP reporting is currently voluntary, but CMS has signaled that it will replace MIPS as early as 2029.

2023 MVP Reporting

41,765 clinicians registered for an MVP with only 20,484 reporting – 6,790 clinicians received their final score from MVP reporting.

- Advance registration is required for MVP reporting, but clinicians can still choose to report traditional MIPS (instead of, or in addition to, an MVP).

- CMS, "expects to see this continue for the next few years, as dual reporting offers an opportunity for clinicians and groups to gain experience with the measures and activities available in their selected MVP, while still being eligible to receive the highest final score available to them."

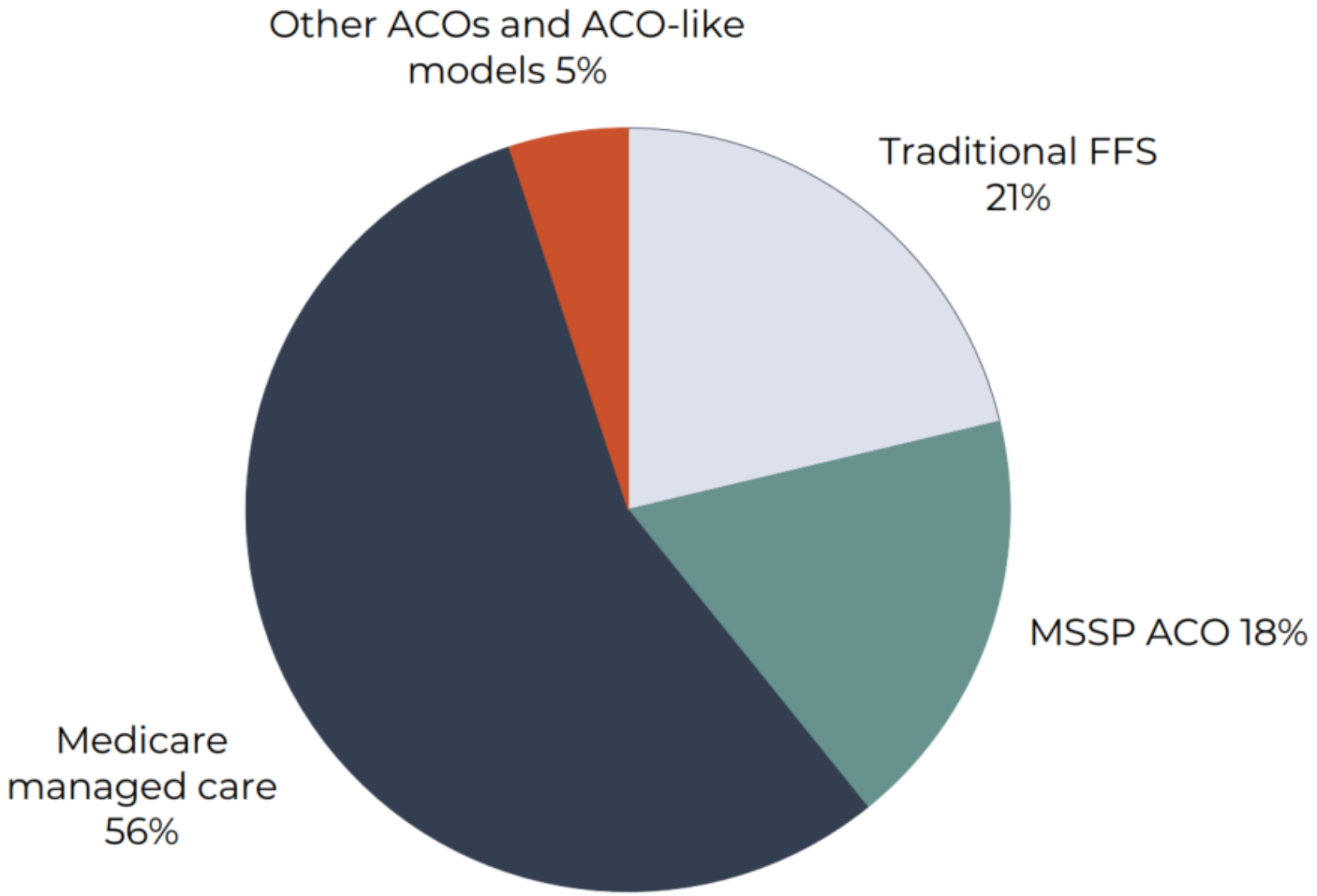
CMS: 2023 QPP Participation and Performance Results

The Universal Foundation

- CMS operates more than 20 quality programs, each with its own set of quality measures
- Several of the 2025 QPP proposals coincide with CMS' National Quality Strategy, an attempt to align quality initiatives across traditional Medicare, Medicare Advantage, Medicaid, CHIP, and Marketplace plans

The Universal Foundation of Quality Measures

Among the 62.5 million Medicare beneficiaries with both Part A and Part B coverage in 2025, approximately three-fourths (79%) are in Medicare managed care or ACO models



Federal Environmental Scan: CMMI

- With $10B in mandatory funding, Congress created the Center for Medicare and Medicaid Innovation (CMMI) in 2010 to testing innovative care delivery and payment models that improve quality and reduce costs to the government.
- The Congressional Budget Office (CBO) found that CMMI increased direct spending by $5.4 billion in its first decade.
- In its nearly 15-year lifetime, only 6 out of more than 50 models have yielded significant savings.

[1]Federal Budgetary Effects of the Activities of the CMMI, Sept, 2023, Congressional Budget Office

Federal Environmental Scan: CMMI

4/28/25: Letter from the U.S. House Committee on Ways and Means to CMS Administrator Mehmet Oz and CMMI Director, Abraham Sutton.

"We believe that with the right leadership, CMMI can produce models that promote value over volume, result in meaningful program savings, improve care for the most vulnerable beneficiaries living in rural and underserved communities, and better incorporate public input."

CMS Strategies for Specialist Value Based Care

- CMS acknowledges that relationships with specialists are needed to increase VBC adoption.

- PCPs represent only 4% of total physician costs

Enhance specialty care data transparency
- Shadow bundles

Incentives with primary care to engage with specialists
- PM/PM to use e-consult platform for referrals
- PM/PM for co-management with a specialist

Incentives for specialists to join population health models
- 2025 MPFS included a request for information
- CMS is investigating an outpatient specialist model

Build momentum on episode-based models (TEAM)
- PCP referral required upon discharge

Ambulatory Specialty Model

- Propose a mandatory model beginning Jan. 1, 2027, and running for five years.
- The focus is on low back pain and congestive heart failure with a **20-patient minimum** threshold over a 12-month period.
- The models would follow the MIPS incentive/penalty payment structure of up to 9%.
- Measures include quality, cost, care improvement, and implementing technology that allows specialists to communicate and share data electronically between patients and their primary care providers.

Ambulatory Specialty Model

- Appreciate CMS efforts to develop a specialist-focused value-based payment model centered on the ambulatory care setting, where individual physicians – rather than health care facilities or physician aggregators – can take the lead.
- Concern that the proposed ASM model relies on the flawed Merit-Based Incentive Payment System (MIPS) and the MIPS Value Pathways (MVP) framework.
- Recommend CMS delay implementation of the new ASM model until the agency gains a clearer understanding of MVP participation trends and outcomes.
- Urges CMS to clarify how ASM participation and attribution would affect or interact with other CMS value-based programs to prevent conflicting requirements, duplicative reporting, and inconsistent payment adjustments.

Unified Agenda: What to Expect?

September

- Annual Policy proposal for Medicare Advantage Plans for 2027
- Proposed ruled to update practice transparency regulations from 2020
- Final regulation governing electronic transactions for prior authorizations (killing the fax machine!)

October

- **Proposed rule for new/modified models under the Center for Medicare and Medicaid Innovation**
- Proposed rule for Medicaid/CHIP to modify the 1115 waiver process, revise state enrollment procedures and update Medicaid managed care state-directed payments

November

- Final Medicare payment rules for hospital outpatient, physicians, home health, and end-stage renal disease
- Policy and payment proposed rule for health insurance exchanges
- Rule finalizing updates to the independent dispute resolution process under the No Surprises Act

December

- Final rule setting a specialty registration process for prescribing controlled substances via telehealth

Monthly Value Based Care Industry Scan

- CMS Value Based Care Programs
- Health Care Costs and Transparency
- Health Equity / Social Determinants of Health
- Innovations
- Market Consolidation / Private Equity
- Medicare Advantage
- Private Payers
- Payment Policy
- Specialty News
- TMA and Organized Medicine

Kim.Harmon@texmed.org

Telemedicine: Use

TMA's 2025 HIT Survey indicates that

75% of physicians use telemedicine for

9% of their patient visits (down slightly from 2023)

Federal Issues:
Medicare Telehealth Geographic Site Restrictions

Pre-COVID	• Originating site must be in a rural/or HPSA-eligible area • Patient's home was not allowed as an originating site, with few exceptions
COVID Flexibilities (thru 9/30/25)	• Geographic site restrictions were waived allowing the patient's home as an acceptable originating site
Upcoming Policy	• Restrictions return for most non-behavioral services • Patient must be in eligible rural/HPSA geographic site • The patient's home is no longer broadly allowed as the originating site
Permanent Exceptions	• Behavioral/mental health: home allowed and no geographic limits • Certain conditions such as ESRD home dialysis, substance abuse, stroke

Originating Site: Where the patient is located during a telehealth visit
Distant site: Where the provider is located
Geographic Restrictions: Rules about urban vs rural, health professional shortage areas (HPSAs), etc.

2026 MPFS: Telehealth

- TMA calls on Congress to remove existing geographic-site restrictions for telehealth so that beneficiaries may continue receiving care in their homes after the current waiver expires on Sept. 30, 2025.

- TMA supports CMS's proposal to permanently extend the existing (and temporary) policy of allowing clinicians to satisfy direct supervision requirements for diagnostic tests, services furnished incident to a physician's services, and some hospital outpatient services through virtual presence using real-time audio/video technology.

TMA Telemedicine Resources

www.texmed.org/telemedicine

Telemedicine in Texas

Telemedicine: Getting Started

TMA's telemedicine resources are designed to help you at any stage of telemedicine adoption and use. Take advantage of these resources and education developed for you, which include guidance on technology tools, policies, procedures, payment, and compliance.

Read the Guide

Trending Telemedicine News

Valuable Screentime: Telemedicine Paves the Way for Increased Access

HHS Removes Home Address Telemedicine Requirement After TMA's Urging

Telemedicine Flexibilities Preserved in Medicare Fee Schedule

Read More

Texas Laws and Regulations Relating to Telemedicine

How well do you understand Texas' laws and regulations relating to telemedicine? This document describes the new Texas legal and regulatory requirements that apply to a physician providing telemedicine medical services.

This white paper was updated in August 2019.

Telemedicine Topics

Trending News

Education

Laws and Regulations

Vendor Evaluation Criteria

Policies, Procedures and Forms

Payment

Remote Patient Monitoring

Telemedicine Education

Get Telemedicine CME through the TMA Education Center.

View the TMA YouTube Telehealth Playlist.

CME is not available for the YouTube webinars (if CME is mentioned in the webinar, it was only for those participating in the live version).

- Telehealth Platform Selection: 52 minutes
- The Telehealth Initiative Virtual Bootcamp I: 2:16
- Redesigning Your Practice: 57 minutes
- Partnering with Patients: 1 hour

Federal Issues: Information Blocking

Practices that unreasonably interfere with access, exchange, or use of electronic health information (EHI), prohibited under the 21st Century Cures Act.

Examples

- Refusing patients timely access to their records
- Charging excessive fees for data sharing
- Deliberately delaying release of results in patient portals

Exceptions

- Protecting privacy, Ensuring security, Preventing harm, and other narrow, federally defined circumstances

Penalties

- Providers: disincentives (loss of program participation, payment impacts)
- Developers/HIEs/HINs: civil monetary penalties (up to $1M per violation)

Federal Issues: Information Blocking

- The Department of Health and Human Services (HHS) recently announced that it will take a more active enforcement stance against health care entities that are restricting the flow of information to patients and other entities and interfering with the access, exchange or use of electronic health information (EHI).
- Currently, information blocking claims can be submitted online through the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT (ASTP/ONC) Report Information Blocking Portal. Through Aug. 31, 2025, there have been over 1,300 possible claims of information blocking reported through the portal.
- The AMA encourages physicians to take advantage of ASTP/ONC's educational resources related to information blocking, as well as additional information from the AMA, including a summary of the June 2024 Final Rule (PDF) that implemented disincentives for providers participating in specific Medicare programs.

2025 Texas Legislative Session

- Starting Sept. 1, SB 922 prevents certain sensitive test results from being electronically transmitted to patients immediately, allowing physicians to convey the information in an understandable and compassionate way. SB 922 is limited to two types of tests: a pathology or radiology report that has a reasonable likelihood of showing a finding of malignancy, or a test result that may reveal a genetic marker.

2025 Texas Legislative Session

- Senate Bill 815 prevents payers and their agents from using algorithms or AI in the utilization review process to “make, wholly or partly, an adverse determination.” In other words, a payer’s determination that care is not medically necessary, appropriate, or is experimental or investigational, must be made by an appropriately trained and qualified human reviewer. SB 815 also grants new authority to the Texas Department of Insurance to audit health plans’ use of algorithms or AI systems in utilization review.

Wasteful and Inappropriate Service Reduction Models (WISeR)

- Begins Jan. 1, 2026, and runs thru Dec. 31, 2031
- Goal is to harness enhanced technologies to streamline the review process for items/services that are vulnerable to fraud, waste, and abuse.
- Participants are companies with expertise managing prior authorization processes for payers using enhanced technology.
- Examples of services include skin and tissue substitutes, electrical nerve stimulators, and knee arthroscopy for osteoarthritis.
- Clinicians/companies may select pre-authorization or their claims will be subject to post-service/pre-payment medical review.

Fraud, Waste, and Abuse

Phishing Update

DEA. The Drug Enforcement Administration (DEA) warns of new fraud schemes in which scammers impersonate DEA personnel to obtain personal information. DEA says it does not ordinarily call registrants regarding investigative matters, nor does the agency demand money or sensitive information.

CMS. Scammers are impersonating the CMS in phishing requests by **fax**, requesting copies of medical records and documentation. The phishing attempts claim that medical records and documentation must be provided for a Medicare audit. In the fraud alert, the CMS reminded Medicare providers and their suppliers that the CMS never initiates audits with a request for medical records via fax.

TMA Top 10 Legislative

- Scope of Practice/Workforce/Graduate Medical Education
- Prior authorization/Gold Carding Clean up, further reduce burden
- Defending Medical Liability Reforms/Indexing the Cap/Tort
- Health Information Technology / Augmented Intelligence
- Women's Health/Abortion Exemptions
- Corporate Practice of Medicine
- Non-competes
- Telemedicine Payment Parity
- Medicaid Reimbursement Rates
- Vaccine Access

89th Session Stats

8,719 → **2,795**

Total number of House & Senate bills filed in the 89th session

Number of bills TMA tracked in the 89th session (32%)

14% of all House & Senate bills filed were passed into law

136+

physicians testified

6,832

Action Alert participants

680

first time AA participants

FIRST 89TH TUESDAYS

Taking Medicine's Message to the Capitol

718

total FTAC participants

253

first time FTAC participants

832

Monday night webinar FTAC participants

JOIN TEXPAC

Insurance Landscape

Alignment	Skepticism	DOGE Effect
Insurers and business community aligned to oppose any and all pro-physician or pro-patient bills.	Key House and Senate committees not keen on reforms, wary of potential to increase premiums.	Any suggestion of overregulation or fraud, waste, and abuse were hyper scrutinized.