2025 Reimbursement, Regulatory & Advocacy Updates for EM.

Presented by: Ed Gaines, JD, CCP
VP, Regulatory Affairs & Industry Liaison

September 22, 2025

ABOUT ZOTEC PARTNERS

At the core of what we do lies a proprietary technology with an experienced team of industry experts, which enables us to deliver cost-effective and fully scalable revenue cycle management services to providers of all shapes and sizes.

- Founded in 1998 by T. Scott Law, CPA
- Headquartered in Carmel, IN
- One of the largest privately held healthcare RCM providers in the country
- Zotec manages procedures across all specialties using our proprietary SOC-1 certified patient accounting platform
- Leading the way to improve the business of healthcare for everyone

Quick Facts

30,000+
Total Nationwide Providers

$8.0+ Billion
Annual Client Collections

130 Million
Annual Procedures

12 Million
Annual ED Visits

AICPA SOC · PCI DSS COMPLIANT · HITRUST

A proven and dependable revenue cycle partner since 1998.

Advocacy

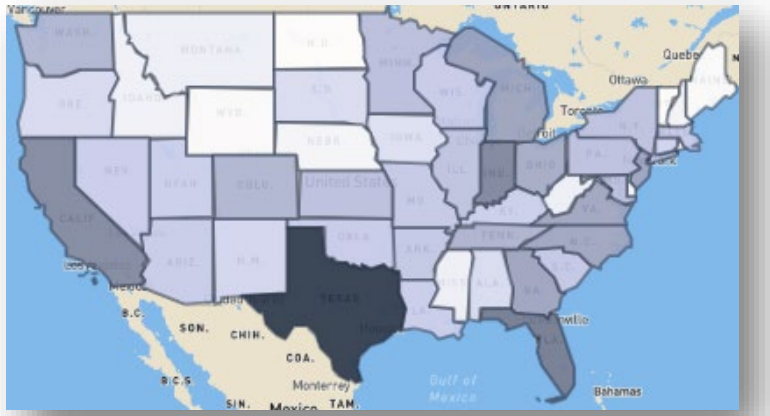
Zotec Political Action Committee (ZPAC)

Everyday, legislation is introduced at the local, state, and federal levels that can directly impact the business of healthcare and our clients, their patients, and our business.

With ZPAC, Zotec gives clinicians intuitive tools they can use to make a difference in their local businesses and on state and federal levels.

Zotec Advocates

- ✓ 55,986 messages sent to lawmakers
- ✓ 7,640+ advocates nationwide



We are dedicated to protecting the business of healthcare. Here is how it works:

- ✓ Tracking hundreds of policies that impact the business of healthcare.
- ✓ Communicating the status of critical legislation to our clients and colleagues.
- ✓ Making it easy to take action with our interactive platform.

ZPAC ZOTEC POLITICAL ACTION COMMITTEE

2026 MPFS Proposed Rule Summary Highlights

2026 Proposed Medicare Physician Fee Schedule

Key Proposals & Potential Medicare Reductions

- On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) released the 2026 Medicare Physician Fee Schedule (MPFS) proposed rule, which includes payment provisions and policy changes to the Quality Payment Program (QPP) and Alternative Payment Model (APM) options and requirements for 2026.
- CMS is then expected to issue the MPFS 2026 final rule in early to mid-November with an effective date of 1/1/26.

2026 Proposed Medicare Physician Fee Schedule

Key Proposals & Potential Medicare Reductions

The change to the MPFS conversion factor (CF) incorporates several factors:

- Beginning CY 2026 there will be **two separate CFs** resulting from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA):
- One for physicians participating in the **Merit-based Incentive Payment System (MIPS)** (where MIPS participants get a 0.25% payment update); and
- Another for physicians that are considered **"qualifying participants"** in an **Advanced Alternative Payment Model (A-APM)** (where qualifying participants receive a 0.75% update).
- Also affecting the CF in CY 2026 are a **budget neutrality adjustment of +0.55%** and a +**2.5% temporary increase for 2026** provided under the *One Big Beautiful Bill Act (OBBBA)*. The OBBBA provisions expire on 12/31/26.

2026 Proposed Medicare Physician Fee Schedule

Key Proposals & Potential Medicare Reductions

Conversion Factor:

- **The CF for services provided by a qualifying APM participant is proposed to be $33.5875, (+3.83%) inclusive of a 0.75% annual update.**
- **Services provided by non-APM participants have a proposed conversion factor of $33.4209, which includes a 0.25% annual update (+3.32%).**
- **Both CFs also include a 2.5% 1-year increase to the MPFS CF included in the OBBBA, as well as a proposed +0.55% budget neutrality adjustment.**

2026 Proposed Medicare Physician Fee Schedule

Impact to Allowed Charges from Policy Changes

- **As a reminder, physician payments were reduced by 2.83% in 2025 after a temporary increase in payments for 2024 expired. Neither the OBBBA nor any current bill actively being considered in Congress addresses the -2.83% Medicare cut in 2025.**
- **Each year CMS estimates the impact to allowed charges from policy changes in the rule as outlined below (Table 92, pg. 1191). These impacts are due in part to changes in the RVUs and the second year of the transition to clinical labor pricing updates and do not account for changes in the CF, sequestration cuts, or the PAYGO cut that could occur in 2026 (see section below).**
- **Please Note:** The 0.75% and 0.25% updates to the CY 2026 qualifying APM and APM and nonqualifying APM CFs, respectively, as well as the single year increase of 2.50% to the CF for CY 2026, are **statutory changes** that **take place outside of Budget Neutrality (+0.55%)**, and therefore, are not captured in the specialty impacts displayed in *Table 92, pg. 1191.

2026 MPFS Proposed Payment

CMS estimates the overall specialty impact to allowed charges from MPFS Policies

Specialty (*Table 92)	Combined Impact: Non-Facility	Combined Impact: Facility	Combined Impact: Total
Anesthesiology	7%	-3%	-1%
Critical Care	7%	-7%	-4%
Diagnostic Testing Facility (Radiology)	0%	-1%	0%
Emergency Medicine	**7%**	**-2%**	**-1%**
Family Practice	6%	-9%	3%
Independent Laboratory	-1%	-3%	-1%
Interventional Radiology	7%	-7%	2%
Interventional Pain Management	6%	-9%	3%
Internal Medicine	6%	-8%	-1%
Nuclear Medicine	1%	-3%	-1%
Nurse Practitioner	5%	-9%	1%
Nurse Anesthetist/Anesthesiology Assistant	10%	-1%	-1%
Pathology	-2%	-3%	-2%
Physician Assistant	4%	-8%	1%
Radiation Oncology/Therapy Centers	-1%	-2%	-1%
Radiology	1%	-3%	-2%

The Medicare Physician Fee Schedule assigns both **facility** and **non-facility** rates for some CPT codes.

- **Facility** rates (e.g., hospitals, ASCs, nursing homes, outpatient departments) are lower because the practice doesn't incur overhead costs.
- **Non-facility** rates (e.g., FSED, office, home) are higher to account for the practice's expenses like staff, equipment, and supplies.

2026 Proposed Medicare Physician Fee Schedule

CMS' Efficiency Adjustment Proposal

CMS proposes a new -2.5% "efficiency adjustment" to work RVUs and the intraservice time component for non-time-based services.

- **This adjustment assumes that as physicians gain experience, the time and intensity needed to perform a service decreases, an efficiency not currently reflected in RVUs due to infrequent updates and reliance on survey data.**
- **The adjustment would not apply to time-based codes such as non-ED E/M visits, care management, behavioral health, and services on the CMS telehealth list. Most surgical, radiology, and pathology services would be affected, resulting in an estimated -1% overall payment reduction.**
- **CMS would calculate the adjustment using a 5-year look-back on the Medicare Economic Index (MEI) productivity updates (2022–2026 for 2026 rates). If finalized, this adjustment would be applied every 3 years.**

2026 Proposed Medicare Physician Fee Schedule

Additional Potential Reductions

With the 2.5% increase to the overall CF there are still additional cuts that could impact reimbursement in 2026.

- **Because the American Rescue Plan was not fully funded, Medicare must recalculate the required spending cut under the "PAYGO" (Pay-As-You-Go) rules.**
- **As a result, this cut is scheduled to return to the Medicare fee schedule in 2026, unless Congress intervenes, as it has done several times in the past to delay these reductions.**

Zotec will continue to actively advocate on behalf of our clients to work with Congress and our contacts to help shape and promote sustainable legislative solutions to address physician reimbursement for the long-term.

2026 Proposed Medicare Physician Fee Schedule

Additional Highlights

Evaluation and Management:

- CMS announced a proposed -2.5% efficiency adjustment to work RVUs, based on the assumption that practitioners will "…accrue gains in efficiency over time."
- However, this reduction **does not apply** to certain code sets, including evaluation and management (E/M) services, **meaning emergency department E/M work RVUs remain unchanged** from 2025 levels in the 2026 proposal.
- That said, emergency E/M codes may see a decrease due to CMSs' proposed changes to practice expense (PE) methodology.

The positive updates in the 2026 CF offset with the negative impacts on the PE-RVUs and should result in a:

- Slight **increase** in the ED E/Ms, and
- Slight **decrease** in most procedures, under the proposed 2026 rule.*

* *This varies by practice and depends on the specific mix of codes that the group uses.*

2026 Proposed Medicare Physician Fee Schedule

Additional Resources

- Fact Sheet
- Proposed Rule on Federal Register

OBBBA: Rural Health Transformation Program

The One Big Beautiful Bill Act (OBBBA)

Rural Health Transformation Program (RHTP)

- **$50B investment** — largest in rural health care since 2003.
  - Immediate relief for rural hospitals + tools for long-term success.
  - Funds address challenges: low patient volumes, workforce shortages, infrastructure needs, outdated technology, and shifting reimbursements.
- **Funding Distribution:**
  - **50%** divided equally among states applying to CMS.
  - **50%** allocated by CMS formula (rural population, facility proportion, low-income patient needs).
  - If all states participate → each receives **$100M+ annually for 5 years.**
- **Why It Matters:**
  - Empowers states to partner with clinicians on tailored solutions.
  - Strengthens sustainability of rural hospitals.
  - Potentially offsets feared reductions in Medicaid coverage due to other provisions of the OBBBA, e.g. “eligibility revalidations”.

Republican CR Stopgap Funding Bill (HR 5371).

Continuing Appropriations & Extensions Act 2026

Health Extenders

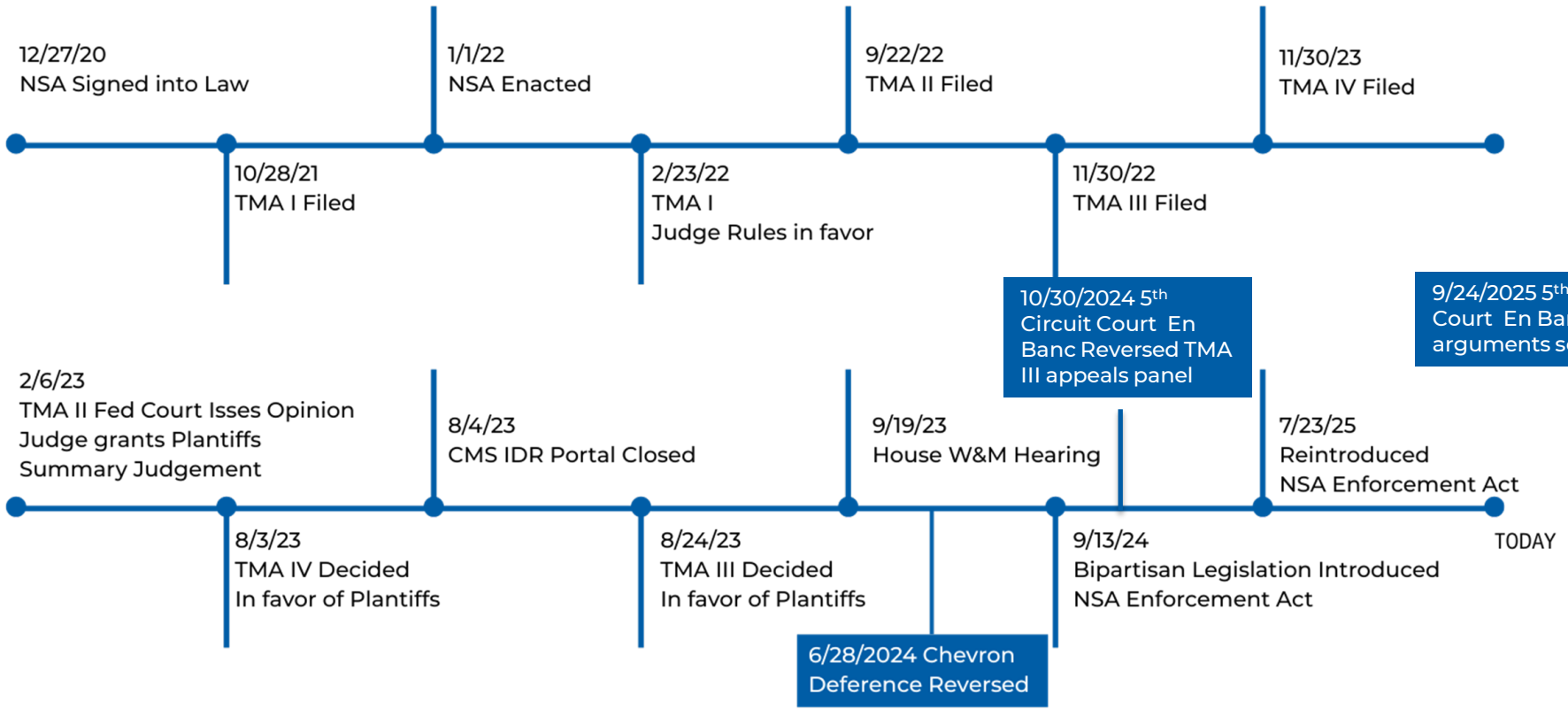
Title II – Medicare:

- **Sec. 206. Extension of the work geographic index floor.** ***This section extends the 1.0 work geographic practice cost index (GPCI) floor used in the calculation of payments under the Medicare physician fee schedule through November 21, 2025.***
- **Sec. 207. Extension of certain telehealth flexibilities. This section extends Medicare telehealth flexibilities through November 21, 2025.**
- **Sec. 208. Extending acute hospital care at home waiver authorities. This section extends the Acute Hospital Care at Home initiative, as currently authorized under CMS waivers and flexibilities, through November 21, 2025.**
- **Sec. 209. Extension of temporary inclusion of authorized oral antiviral drugs as covered Part D drugs. This section extends Medicare Part D coverage of certain oral antiviral drugs through November 21, 2025.**
- **Sec. 401. Delaying Medicaid DSH reductions.** This section delays the Medicaid disproportionate share hospital (DSH) cuts, which are set to begin on October 1, 2025. The 9 remaining DSH cuts would be in effect beginning on November 21, 2025, through the remainder of FY26 and for FY27 and FY28.

No Surprises Act – Independent Dispute Resolution

The No Surprises Act (NSA)

Legislative Spotlight: Passage Implementation, Reaction, Impact

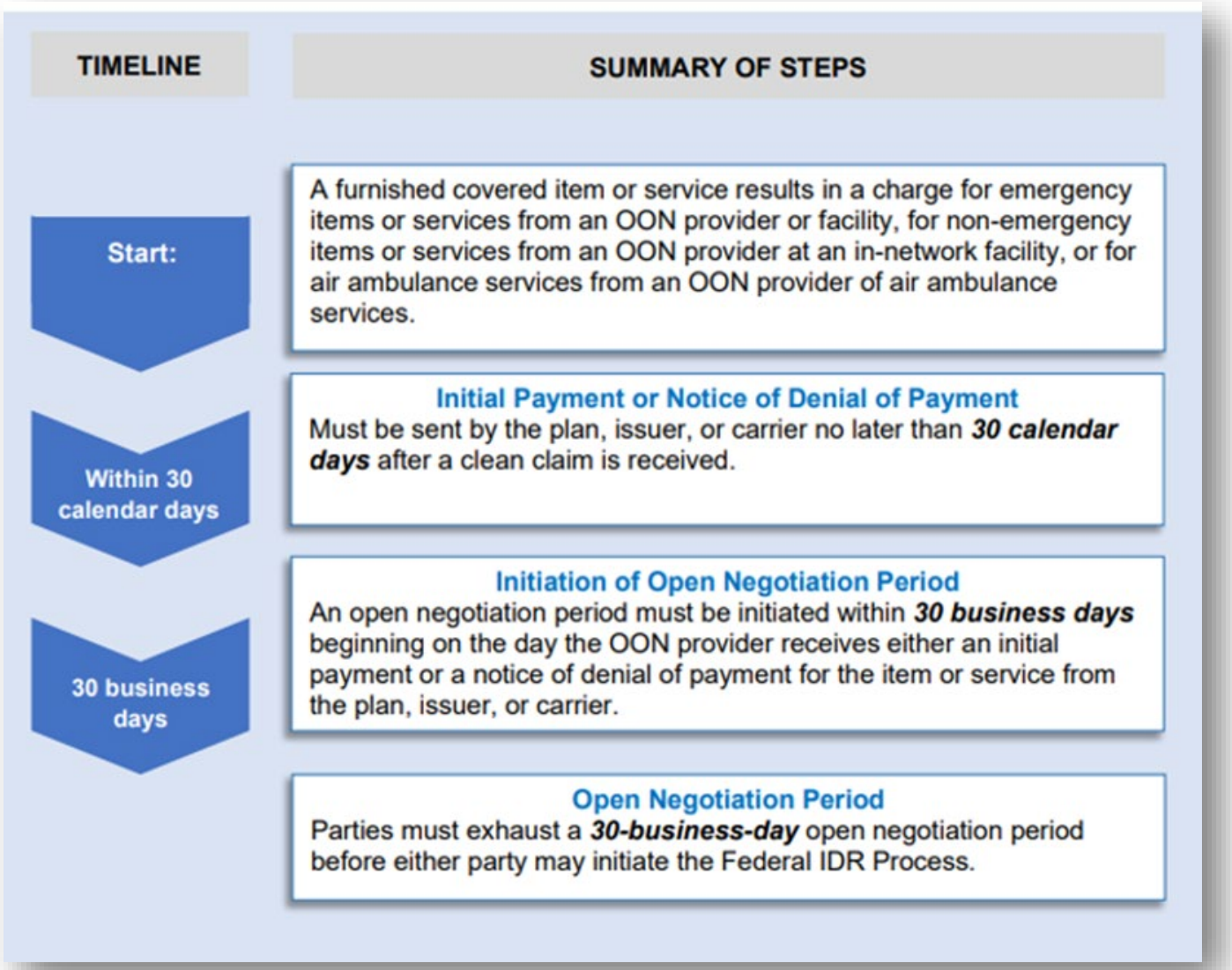


Passing a bill is only the first step. The real challenge comes with implementation and managing the public's reaction.

The NSA's rollout highlights how difficult implementation can be, creating significant challenges for physicians.

What is the IDR process?

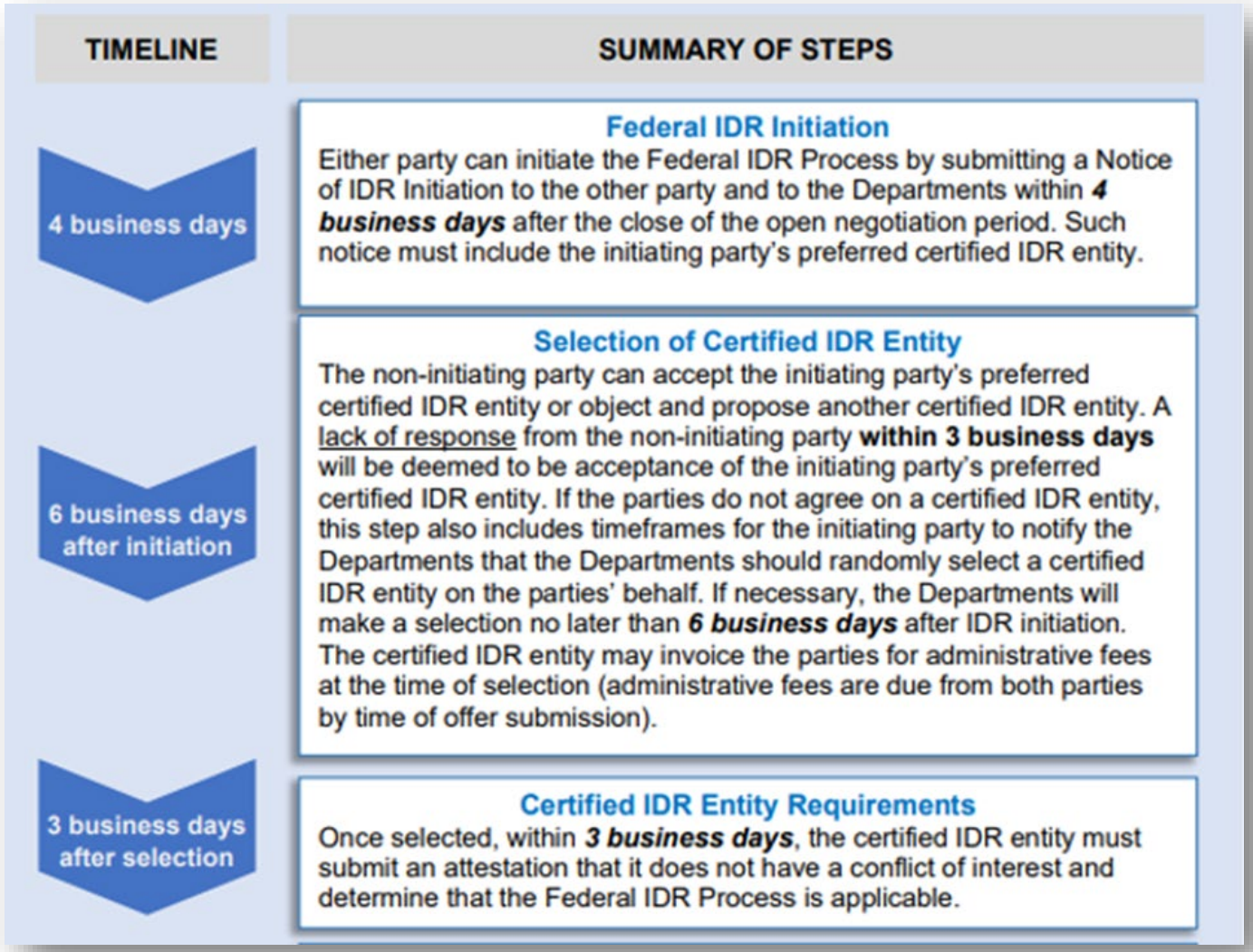
*Key Steps in the NSA/IDR Process: Steps Preceding the Federal IDR Process**



***Source: CMS Slides**

IDR – cont'd

*Key Steps in the NSA/IDR Process: Federal IDR Process Overview**



TIMELINE	SUMMARY OF STEPS
4 business days	**Federal IDR Initiation** Either party can initiate the Federal IDR Process by submitting a Notice of IDR Initiation to the other party and to the Departments within ***4 business days*** after the close of the open negotiation period. Such notice must include the initiating party's preferred certified IDR entity.
6 business days after initiation	**Selection of Certified IDR Entity** The non-initiating party can accept the initiating party's preferred certified IDR entity or object and propose another certified IDR entity. A lack of response from the non-initiating party **within 3 business days** will be deemed to be acceptance of the initiating party's preferred certified IDR entity. If the parties do not agree on a certified IDR entity, this step also includes timeframes for the initiating party to notify the Departments that the Departments should randomly select a certified IDR entity on the parties' behalf. If necessary, the Departments will make a selection no later than ***6 business days*** after IDR initiation. The certified IDR entity may invoice the parties for administrative fees at the time of selection (administrative fees are due from both parties by time of offer submission).
3 business days after selection	**Certified IDR Entity Requirements** Once selected, within ***3 business days***, the certified IDR entity must submit an attestation that it does not have a conflict of interest and determine that the Federal IDR Process is applicable.
10 business days after selection	**Submission of Offers and Payment of Certified IDR Entity Fee** Parties must submit their offers not later than ***10 business days*** after selection of the certified IDR entity. Each party must pay the certified IDR entity fee, (which the certified IDR entity will hold in a trust or an escrow account), and the administrative fee when submitting its offer (unless the administrative fee has already been paid).
30 business days after selection	**Selection of Offer** A certified IDR entity has ***30 business days*** after its date of selection to determine the payment amount and notify the parties and the Departments of its decision. The certified IDR entity must select one of the offers submitted.
30 calendar/ business days after determination	**Payments Between Parties of Determination Amount & Refund of Certified IDR Entity Fee** Any amount due from one party to the other party must be paid not later than ***30 calendar days*** after the determination by the certified IDR entity. The certified IDR entity must refund the prevailing party's certified IDR entity fee paid within ***30 business days*** after the determination.

Source: CMS Slides

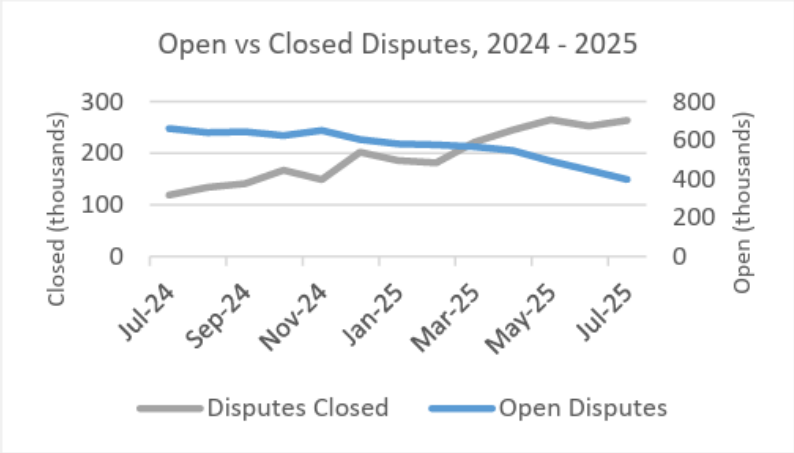
New CMS data on clearing the backlog of IDRs

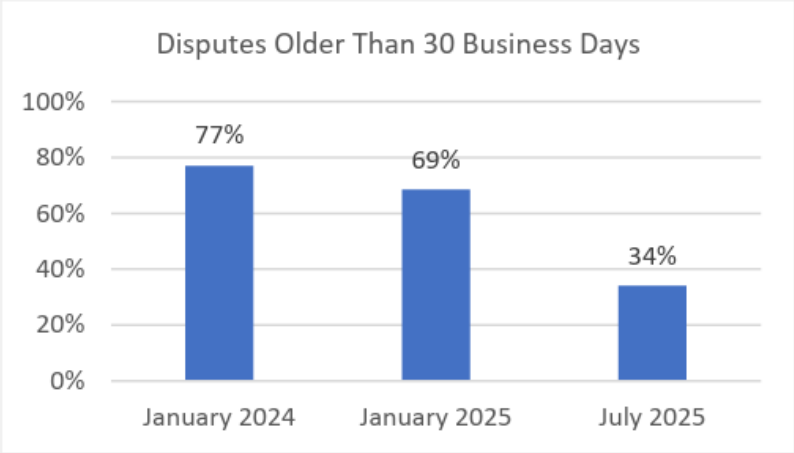
Rates of ineligible claims are also being reduced: https://www.cms.gov/files/document/fact-sheet-clearing-independent-dispute-resolution-backlog.pdf

Fact Sheet: Clearing the Independent Dispute Resolution Backlog

Now, as of July 2025, **96.5% of all IDR disputes submitted since the beginning of the program have either been resolved or are less than 30 business days old**. (30 business days from IDR entity selection is the general target length of time for dispute resolution under the NSA.)

The majority of disputes – 90% of all disputes submitted – have been resolved. And, of the 363,099 disputes still outstanding as of July 2025, only 34% are more than 30 days old.





Figures 1a and 1b: The Departments' work with certified IDR entities has sharply reduced open IDR disputes in 2025, increased monthly dispute closures, and decreased the percentage of disputes open more than 30 business days.

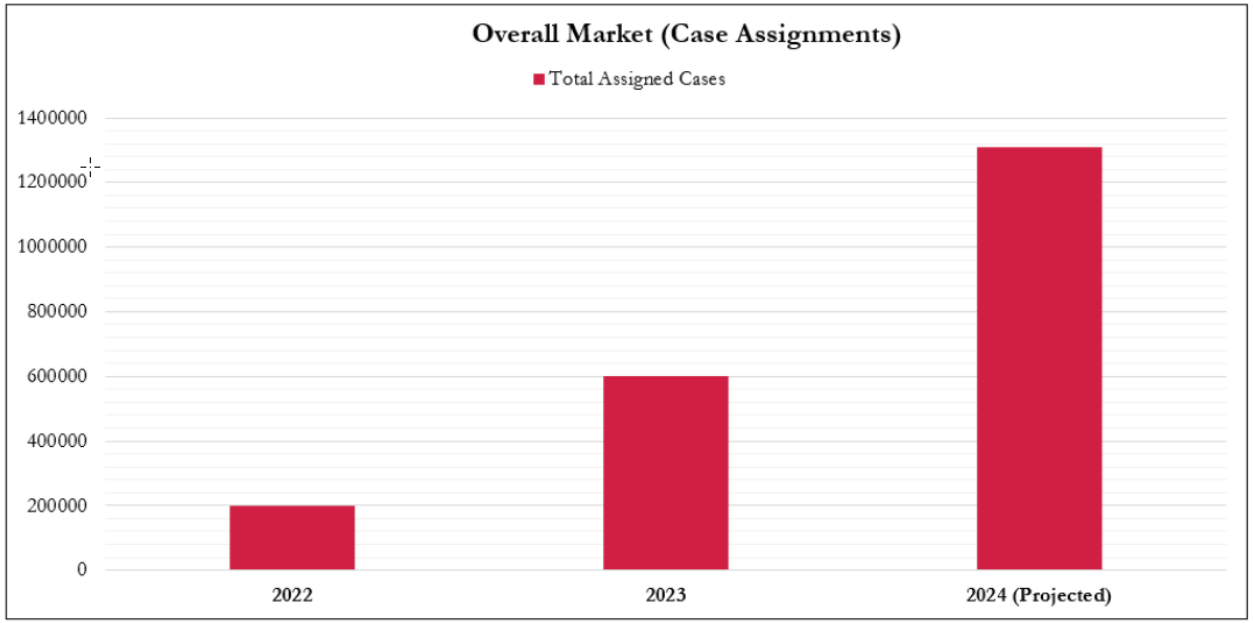
ZiNG

Zotec Intelligent
Negotiation Guide

Highlighting opportunities for improved rates via the IDR process

New data from FHAS: Dec. 2024—90% of the claims are eligible for IDR.

IDR: Continual Growth



Disputes Filed
2022: 200,000
2023: 600,000
2024: 1,308,000

SOLUTIONS SUMMIT 2025
The Trailhead to Peak Performance

Win Rates by ED E&M, Offer Avg.—FHAS data: ED win rates are maintaining or >.

2024: Year In Review

Service Code (Total)						
Code	**Type**	**DLI Count**	**Dispute Count**	**IP Offer Avg.**	**NIP Offer Avg.**	**IP Win%**
99284	Level 4 Emergency Visit	136847	76551	$1,838.89	$441.47	85.65%
99285	Level 5 Emergency Visit	104744	54110	$1,949.80	$605.51	85.37%
99283	Level 3 Emergency Visit	46356	27786	$1,368.48	$281.72	83.17%
99291	Level 1 Critical Care	13313	8441	$3,186.11	$668.22	83.10%
99282	Level 2 Emergency Visit	1465	881	$2,010.37	$369.92	72.18%
99292	Level 2 Critical Care	441	355	$3,713.03	$511.58	80.58%
99281	Level 1 Emergency Visit	184	165	$899.67	$154.21	80.20%

Why IDR

Goal: Fair In-Network Rates

Challenges

- **Health plans are unresponsive or are actively requesting major contract rate cuts.**
- **Health plan claim adjudication practices, e.g. denials, downcoding & pre-payment reviews, are increasingly driving ED groups to at least consider an OON strategy.**
- **Length of time from filing the IDR to payment continues to be an issue but is improving.**
- **Patients are held harmless.**

Opportunity

- **Physician groups are winning IDR at rates at 85-90%. Even losses are generating additional revenue.**
- **IDR recovery rates can be 3-6X of the initial payment (QPA) per the CMS Public Use File (PUF) CY '24 data.**
- **Health plans are paying the IDRE fees in this "loser pays" system.**
- **Groups protect their hospital contracts –this enables them to ask lower stipends and potentially expand hospital contracts.**

What You Can Do

Take Action Today!

Download the Advocacy Toolkit

Stay Informed & Connected Additional Resources

A+ZPAC
A Healthcare Advocacy Blog
ZOTEC POLITICAL ACTION COMMITTEE

ZOTECANSWERS
A Podcast Series

Thank you!

Ed Gaines JD, CCP

VP, Regulatory Affairs &
Industry Liaison
egaines@zotecpartners.com