FARRAGUT
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Farragut's Five Things to Know About CMS' Proposed Physician Rates for 2025

Last week, CMS released the CY 2025 Proposed Physician Fee Schedule, which maps out where the agency intends to move on physician and practitioner reimbursement under Medicare Part B for the next year. Below, Farragut summarizes some of the most important provisions included in the proposal and our outlook for implementation. CMS will be accepting comment on the rule through September 9th, and will likely move to finalize the rule in early November. As we have noted for the past few years, the rule will not be implemented until January 2025, which is crucially important as it allows a lame-duck session of Congress to likely intervene to ameliorate proposed cuts via end-of-year legislation. *Farragut notes that the 2,000+ page PFS is far-reaching and includes nuances and provisions beyond those outlined below, and we will be following up with additional insights; we encourage you to reach out with any sector or asset-specific questions.*

Key Observations:

1. As expected, lingering budget neutrality pressure feeds into a roughly 2.8% cut to the PFS conversion factor to be applied across all specialties.

2. Following a years-long trend, CMS continues to build out reimbursement opportunities for primary care practices.

3. CMS is proposing to extend a limited number of telehealth flexibilities, but many will expire at the end of 2024 unless Congress takes action.

4. While there are macro headwinds on the PFS, there are also targeted bright spots in the proposal – including *tailwinds for* ***physical therapy***, ***gastroenterology***, *and* ***behavioral health***.

5. As is often the case in an election year, CMS chose to punt some of the most controversial provisions floated in prior years' rulemaking – including rebasing the Medicare Economic Index and changing reimbursement for skin substitutes – beyond 2025.

Further Discussion:

1. As expected, lingering budget neutrality pressure resulted in a proposed -2.8% cut to the PFS conversion factor to be applied across all specialties.

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For CY 2025, CMS is proposing a PFS conversion factor of $32.3562 – which is a -2.8% reduction relative to the current conversion factor which has been in place since Mar. 9th, 2024 (*Farragut notes that Congress provided relief to the CY 2024 conversion factor mid-March of this year, and accordingly the CY 2025 reduction is a softer decline when compared to the annualized rate paid in 2024*).

The decrease in the PFS conversion factor reflects three primary forces:

1. Under MACRA, there is **no inflationary adjustment** built into the PFS;
2. From 2021 to 2025, Congress and CMS have been **phasing-in budget neutrality adjustments** via annual relief (which was necessitated by CMS' decision to substantially increase office/outpatient Evaluation and Management (E/M) codes in CY 2021 rulemaking) and the remaining 2.93% of relief is set to end at the start of 2025;
3. CMS is proposing a **modest 0.05% positive budget neutrality adjustment** based on RVU changes in the 2025 proposal.

While the cut to the PFS conversion factor is a headwind across PPMs, it is also a macro pressure that stakeholders have known was coming. Farragut expects that when the rule is finalized, the conversion factor will likely mirror closely to what is proposed – as CMS does not have the authority to waive budget neutrality or create an inflationary update. Instead, efforts for relief will likely ramp up toward the end of the year – with stakeholders once again seeking congressional relief, as they have for the last several years. While there are growing signals of congressional support for a larger overhaul of the PFS to address inflationary pressure, we note that this is a heavy lift in an election year – accordingly, we view it likely that near-term solutions will amount to yet another year of phasing-in/delaying pressure on the conversion factor.

Below, Farragut maps out an impact table for select specialties based on the proposed conversion factor – in addition to other forces, such as the final year of clinical labor repricing. Notably, the specialty impact table included in the CY 2025 proposal does not include the -2.93% cut from the end of statutory relief – which can cause confusion for providers. Accordingly, we provide both CMS' estimates and Farragut's net estimates for 2025.

	CMS Reported Impact	Farragut's Estimated Impact
Cardiology	0%	-3%
Dermatology	0%	-3%
Gastroenterology	0%	-3%
General Practice	0%	-3%
Ophthalmology	-1%	-4%
Orthopedic Surgery	-1%	-4%
Radiology	0%	-3%
Vascular Surgery	-2%	-5%

Additionally, Farragut emphasizes that nuances exist on expected reimbursement based on individual asset's code utilization and site-of-service, and we encourage interested parties to reach out to have a more fulsome discussion on asset-specific outlooks.

2. Following a years-long trend, CMS continues to build out reimbursement opportunities for primary care practices.

The last several years of the PFS have shown a continued trend of efforts to increase reimbursement to primary care and primary care-like providers. In 2021, CMS substantially increased reimbursement for office/outpatient E/M services; and in 2024, CMS launched an add-on E/M code G2211 to create new reimbursement opportunities for longitudinal patient-provider relationships where the provider serves as the continuing focal point for care and/or with medical care that is part of treatment of an ongoing single, serious or complex condition. For 2025, CMS is once again proposing to increase reimbursement opportunities, including by clarifying that G2211 may be billed at the same time as an annual wellness visit, vaccine administration, or other preventive service (reducing some of the previous Modifier-25 exclusion).

Additionally, CMS is proposing to establish a set of advanced primary care management (APCM) codes, which would incorporate elements of existing care management services (e.g., chronic care, principal care, and transitional care) into a bundle that "reflects the essential elements of the delivery of advanced primary care." CMS states that the new codes would aim to reduce administrative burden associated with current coding/billing rules, and that these codes may be billed by practitioners who use an advanced primary care model of care delivery when they are the "continuing focal point for all needed health care services and responsible for all the patient's primary care services." The new code set would consist of three tiers, based on the number of chronic conditions and the patient's medical/social complexity.

3. CMS is proposing to extend a limited number of telehealth flexibilities, but many will expire at the end of 2024 unless Congress takes action.

A number of telehealth flexibilities granted during the PHE are set to sunset at the end of 2024, and while CMS is proposing to allow a handful of these flexibilities to continue, it would allow others to expire and require Congress to intervene. *Perhaps most importantly, it will take action by Congress to extend flexibilities for geographic location and site of service (i.e., urban locations and in the home) for the majority of services, with the exception of permanent flexibilities already granted for behavioral health and monthly ESRD assessments. This poses a risk of substantially curtailing access to telehealth services for Medicare beneficiaries – but stakeholders are actively pushing Congress to extend flexibilities by another two years.*

Outside of those flexibilities, CMS is proposing to extend a handful of allowances, including: suspension of frequency limitations for subsequent inpatient/nursing facility visits for 2025; continued allowance for practitioners to provide their practice location address instead of their home address when providing telehealth services from their home in 2025; allowance for direct supervision to occur via audio-video telehealth for select services on a permanent basis (and through 2025 for other services); and coverage of two-way audio-only telehealth when the beneficiary is in their home (practitioner must still be capable of audio-video).

4. While there are macro headwinds on the PFS, there are also targeted bright spots in the proposal – including tailwinds for physical therapy, gastroenterology, and behavioral health.

Given the macro headwinds at play, Farragut expects that the overarching reaction by physician groups will be negative toward the proposal. However, there are several proposed policy changes that create targeted tailwinds, including:

- **Physical/occupational therapy supervision:** CMS proposes to lower supervision requirements for PTs and OTs enrolled in private practices, to be on par with institutional providers. Under the proposal, CMS would remove requirements for direct supervision of PTAs and OTAs and instead require general supervision. This change would allow private practices to furnish procedures under overall direction by the PT/OT, but not require them to be present in the treatment location and immediately available.
- **Colorectal cancer screening:** CMS proposes to add coverage for CT colonography and expand the definition of a "complete colorectal cancer screening" to include follow-on screening colonoscopy after Medicare covered blood-based biomarker CRC screening tests return a positive result (thereby removing a barrier of patient cost-sharing).
- **Opioid Treatment Programs:** CMS proposes to make a number of confirmatory changes on telehealth in line with the Feb 2024 SAMHSA regulations, such that Medicare will permanently allow for audio-only telehealth visits for periodic assessments for OTP treatment with methadone and for audio-visual telehealth initiation of methadone. Additionally, CMS is proposing to increase payment for intake activities to account for the value of Social Determinants of Health risk assessments; as well as create reimbursement codes for newly FDA-approved Opvee and Brixadi.

5. As is often the case in an election year, CMS is punting some of the most controversial provisions floated in prior years' rulemaking – including rebasing the Medicare Economic Index and changing reimbursement for skin substitutes – beyond 2025.

While the CY 2025 proposal includes several provisions that would take effect next year, Farragut notes that some of the most controversial provisions that could have been included have been punted into future rulemaking.

These policies that are being kicked down the road include:

- **Proposal to rebase the Medicare Economic Index (MEI):** In 2023 rulemaking, CMS signaled interest in rebasing the MEI in the mid-2020s, which would allow for the relative cost weights of physician work RVUs, practice expense RVUs, and malpractice insurance RVUs to be reweighted and reflect the growing relative cost of staff's labor. *If enacted as initially proposed, this would lead to material tailwinds for many PPMs in the office setting, but result in decreased professional reimbursement for services furnished in the facility – decreasing some of the delta between the two settings*. However, CMS has been persuaded by stakeholders to delay adjustments until more data sources are reviewed – including the AMA's current data collection

which is anticipated to be completed in late 2024. Overall, CMS appears interested in updating data inputs on a more regular and predictable basis – with the goal of balancing stability in payments and accuracy.

- **Changes to skin substitutes:** In 2023 rulemaking, CMS signaled interest in treating and paying for skin substitute products used in the physician office as "incident-to-supplies" under the PFS. However, the proposal garnered significant stakeholder concern and pushback over how it would impact payment for individual codes, prompting CMS to continue to delay material policy reform. Accordingly, CMS will continue to consider reform to payment methodology, as well as including skin substitutes as a refundable drug when discarded, in future rulemaking.

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