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November 5, 2024

Farragut's Five Things to Know About CY 2025 PFS and ASC/OPPS Final Rules

On November 1st, CMS released the CY 2025 Final Physician Fee Schedule, as well as the CY 2025 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule. Below, Farragut summarizes the most important provisions included in the rules. *Notably, the rules tracked closely against what was included in this summer's proposals. Accordingly, their release is potentially less meaningful as a new signal for where CMS intends to go and more important as the start of a clock for stakeholders to work with Congress and secure more favorable legislative provisions in the lame duck – which Farragut will be tracking closely.*

Key Observations:

1. As expected, CMS finalized a -2.8% cut to the Physician Fee Schedule conversion factor across all specialties, which was telegraphed in the proposed rule and represents the continued phase-in of the 2021 E/M budget neutrality adjustments.

2. The PFS builds on CMS' years-long trend of support for primary care and related services.

3. The PFS continues to create winners and losers – with behavioral health, physical therapy, and gastroenterology seeing targeted gains, whereas select orthopedic and ophthalmology practices could see more pressure driven by scrutiny around transfer of care.

4. In CY 2025, CMS is increasing ASC and OPPS payment rates by 2.9% – slightly stronger than in the proposed rule due to the strength of the hospital market basket.

5. Congress will have a busy lame duck session, with many provisions – including relief to the PFS and extension of telehealth flexibilities – competing for oxygen.

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Further Discussion:

1. As expected, CMS finalized a -2.8% cut to the Physician Fee Schedule conversion factor across all specialties, which was telegraphed in the proposed rule and represents the continued phase-in of the 2021 E/M budget neutrality adjustments.

For CY 2025, CMS is calling for a PFS conversion factor of $32.3465 – which is a -2.8% reduction relative to the current conversion factor which has been in place since Mar. 9, 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 is near identical to what CMS proposed in July, and 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 0.02% positive budget neutrality adjustment** based on RVU changes in the 2025 rule.

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 and they have been actively discussing relief with Congress – which we discuss later.

Below, Farragut maps out an impact table for select specialties based on the 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 rule 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	-2%	-5%
Orthopedic Surgery	-1%	-4%
Radiology	0%	-3%
Vascular Surgery	-2%	-5%

Additionally, Farragut emphasizes that nuances exist based on individual assets' 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. The PFS builds on CMS' years-long trend of support for primary care and related services.

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 increasing 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). *Interestingly, in response to commenters recommending the add-on code also be permitted with other types of E/M such as those furnished in nursing facilities or a patient's residence, CMS noted that they may consider whether an add-on for longitudinal care should be included in future rulemaking. This signals a potential tailwind to contract medical management and primary care in residential settings (e.g., nursing homes) in the medium-term.*

Additionally, CMS is establishing a set of advanced primary care management (APCM) codes for use by practitioners who serve as the "continuing focal point for all needed health care services and are responsible for all the primary care services." The codes (which consist of three tiers, based on the number of chronic conditions and the patient's medical/social complexity) are similar to existing care management services (e.g., chronic care management, principal care management) with the notable differentiation that they are not time-based, which CMS hopes will lower administrative burden and potentially open up utilization. The codes can be reported by a single practitioner once per month – accordingly CMS will be monitoring to ensure there is not duplicative billing of the code by multiple practitioners.

3. The PFS continues to create winners and losers – with behavioral health, physical therapy, and gastroenterology seeing targeted gains, whereas select orthopedic and ophthalmology practices could see more pressure driven by scrutiny around transfer of care.

The nature of budget neutrality tends to create winners and losers – as a targeted spending increase must be offset by spending cuts, which is reflected in the PFS conversion factor discussed above. Additionally, policy changes can create more targeted tailwinds and headwinds.

Bright spots within the CY 2025 PFS include:

- **Behavioral health:** A host of tailwinds support behavioral health providers, including the continued phase-in of rate increases for timed behavioral health codes from 2024 to 2027, increased rates for OTP's intake activities and periodic assessments to account for the value of Social Determinant of Health risk assessments, new payment opportunities related to OUD care coordination/ patient navigation/ peer recovery support, and new, separate payment for safety planning interventions and digital mental health treatment devices.
- **Physical/occupational therapy supervision:** CMS is lowering supervision requirements for PTAs and OTAs enrolled in private practices, to be on par with institutional providers. Under the change, CMS will remove requirements for direct supervision of PTAs and OTAs and instead require general supervision. This change allows private practices to furnish procedures under overall direction by the PT/OT, but does not require them to be present in the treatment location and immediately available. Of note, this change does nothing to mitigate the rate differential between a PTA and PT.
- **Colorectal cancer screening:** CMS is adding coverage for CT colonography and expanding 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).

The PFS also creates pressure on select ophthalmology and orthopedic practices by finalizing a change to transfer of care modifiers for 90-day global surgery packages (Farragut notes that ophthalmology and orthopedic assets more commonly use affected 90-day codes). Specifically, CMS will broaden the applicability of transfer of care Modifier -54 when a practitioner plans to furnish *only the surgical portion* of the package (now including both formal *and other* transfers of care). This is expected to create pressure for select ophthalmology and orthopedic practices where the patient is seeking follow-up care at other practices (e.g., this could be the case when a patient wants to seek follow-up at a closer or lower acuity location, accordingly Farragut expects this could have more of an impact for assets focused on rural geographies or for hospitals).

4. In CY 2025, CMS is increasing ASC and OPPS payment rates by 2.9% – slightly stronger than in the proposed rule due to the strength of the hospital market basket.

For CY 2025, CMS is increasing OPPS and ASC payment rates by 2.9%, which is 0.3% higher than proposed in July. This update is based on the hospital market basket increase of 3.4% and reduced by a 0.5% productivity adjustment. This parallel payment increase reflects CMS' temporary policy to update the ASC fee schedule by the hospital market basket from CYs 2019 to 2025 – *and in CY 2026 rulemaking Farragut will be paying careful attention to whether CMS seeks to implement a different market basket methodology or inquire into cost-reporting to justify a certain methodology.*
Additionally, CMS is adjusting the conversion factor by the wage index budget neutrality factor, such that the final ASC conversion factor is $54.895 (a 2.6% increase).

Beyond the rate increase, another favorable update is that CMS is finalizing refinements to the existing bundled payment policy for diagnostic radiopharmaceuticals – such that CMS will pay

separately for any diagnostic radiopharmaceutical with a per-day cost greater than $630 (and remove their costs from the payment amounts for the nuclear medicine tests). This threshold represents ~two times the volume-weighted average cost currently associated with diagnostic radiopharmaceuticals. All qualifying radiopharmaceutical products will be separately payable based on their Mean Unit Cost derived from hospital claims data. *Overall, Farragut notes that the policy to reimburse separately for high-cost diagnostic radiopharmaceuticals is likely to provide a tailwind, although it is a higher threshold than what some stakeholders had advocated for.*

Also of interest within the rule is the update to the ASC Covered Procedure List. The Biden Administration continued its slow-paced trend of only a few codes being added to the ASC CPL per year – with two adrc therapy codes and nineteen dental codes being added for 2025. The other 71 codes that stakeholders submitted for consideration on the ASC CPL were not approved by CMS for the list. *Of note, Farragut highlights that the majority of the codes stakeholders were advocating for (but denied) were cardiovascular – with the majority of cardio codes denied because they have associated inpatient admission and/or longer-lasting patient monitoring, and the majority of vascular codes denied because they are already packaged procedures. Overall, Farragut expects stakeholders within cardiovascular to continue to advocate for more procedures to be permitted in the ASC in the medium-term, but the pacing of which could depend on the next administration.*

From Farragut's review, we note that the final rule holds little meaningful difference from the proposed rule and rather focuses on finalizing earlier proposed text.

5. Congress will have a busy lame duck session, with many provisions – including relief to the PFS and extension of telehealth flexibilities – competing for oxygen.

The passage of the final rules and the impending election start the clock for a crowded lame duck agenda. In September, Congress passed a Continuing Resolution that maintains government funding at FY 2024 levels through Dec. 20, 2024 – accordingly, in the lame duck Congress must pass funding legislation (though it is very possible they will opt for temporary funding as opposed to passing funding for all of FY 2025). Further, Congress will need to take up the National Defense Authorization Act and numerous healthcare extenders that are authorized only through 2024.

Within a large end-of-year bill, healthcare stakeholders will seek to include riders that support providers, including:

- **PFS relief:** Since Dec. 2020, Congress has regularly intervened in end-of-year legislation to phase-out the budget neutrality pressure on the PFS conversion factor. *Farragut believes that Congress will likely be amenable to providing similar relief for 2025. This could look like phasing in the -2.8% pressure across 2025 and 2026 (e.g., allowing a 11.4% cut in 2025 and the remaining -1.4% in 2026) or stakeholders could be more successful in securing a temporary boost to PFS rates that accounts for inflationary pressure (e.g., the Medicare Patient Access and Practice Stabilization Act would provide a one-year fix for 2025 that would punt the -2.8% pressure into 2026 and provide for a ~1.9% increase to the CF in 2025).*

- **Telehealth:** While the 2025 PFS includes some sought-after telehealth provisions (e.g., continued coverage of two-way audio-only telehealth when the beneficiary is in their home, services added to the Medicare Telehealth Services List, and provider address flexibilities), there are several PHE-era flexibilities that are slated to sunset in 2025 without Congress intervention. Specifically, Congress must act to keep both geographic and originating site flexibilities (for services other than behavioral. which is already locked in), or flexibilities will expire on Dec. 31, 2024. *Farragut believes Congress is likely to extend telehealth flexibilities on a temporary basis, with many proposals introduced earlier this year signaling interest to extend flexibilities for two years through Dec. 2026.*
- **PAYGO:** There is a looming -4% cut across Medicare payments that was triggered by spending under the American Rescue Plan in 2021. Congress has previously delayed implementation of this cut twice, and *Farragut expects that Congress will continue to kick the can down the road*.

Overall, Farragut anticipates that short-term fixes are likely to squeeze their way into an end-of-year package, whereas more substantial, long-term policy changes are likely to get punted into the next Congress. Additionally, we note that while relief is likely to be passed prior to the start of CY 2025, Congress has been known to pass early- to mid-year relief when they miss a deadline.

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