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2025 Proposed Physician Fee Schedule Cuts Payments Again

On July 10, 2024, the Centers for Medicare & Medicaid Services (CMS) released its proposed Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2025. In addition to the agency's suggested cut to physician payments, the proposed rule also announced new covered services.[1] According to CMS, the proposed rule "reflect[s] a broader Administration-wide strategy to create a more equitable health care system that results in better accessibility, quality, affordability, empowerment, and innovation for all Medicare beneficiaries."[2]

For CY 2025, CMS proposes to *decrease* the MPFS conversion factor by $0.93, to $32.36 (a 2.80% reduction from the 2024 conversion factor of $33.29).[3] Conversion factors are applied to relative value units (RVUs), i.e., the resources required to furnish a service, to become payment rates. This decrease reflects: the expiration of the 0.00% conversion factor update under the Medicare Access and CHIP Reauthorization Act (MACRA); a 0.05% adjustment for budget neutrality; and a 2.93% statutory increase in payment for CY 2024.[4] If finalized as proposed, this will be the fifth straight year that the conversion factor has been decreased.

In addition to payment rate changes, CMS proposes establishing coding and payments for a new set of Advanced Primary Care Management (APCM) services.[5] Physicians and non-physician practitioners (NPPs) who participate in advanced primary care models can begin billing for APCM services on January 1, 2025.[6] The services would include parts of existing care management and communication technology-based services and reflect the essential parts of advanced primary care delivery, including chronic care management, transitional care management, and principal care management.[7] CMS anticipates that these new codes will "better recognize and describe advanced primary care services, encourage primary care practice transformation, help ensure that patients have access to high quality primary care services, and simplify billing and documentation requirements."[8]

CMS also proposes adding several services to the Medicare Telehealth Services List.[9] Beginning CY 2025, CMS plans to allow interactive telecommunications, which includes two-way, real-time, audio-only communication tools, for any telehealth services provided to beneficiaries in their home.[10] Providers who are technically capable of using a telecommunications system may use this method if their patient does not consent or is not able to use video technology.[11] CMS also plans to continue permitting distant site practitioners to use the location where they are enrolled as a practitioner, rather than their home address, when providing telehealth services.[12] Further, CMS proposes extending the definition of direct supervision – which requires practitioners to be physically present for certain services – to include virtual presence, through real-time visual and audio communications.[13] CMS also intends to continue their policy of allowing teaching physicians to be virtually present for services furnished virtually from a teaching setting, through December 31, 2025.[14]

Other proposals CMS suggested for 2025 include, but are not limited to:

(1) Codifying the *Inflation Reduction Act of 2022*'s mandate that drug companies pay "inflation rebates" if they raise prices for certain Medicare Part B and D drugs faster than the rate of inflation.[15]
(2) Requesting feedback for a proposed model that would engage specialist providers in value-based care through the Merit-based Incentive Payment System's (MIPS') Value Pathways;
(3) A request for information on CMS's community health integration services, social determinants of health risk assessment, and principal illness navigation services;
(4) New payments and codes for caregiver training and support that could be provided via telehealth; and
(5) Flexibilities for opioid treatment programs (OTPs), including allowing telehealth and audio-only visits for follow-up appointments.[16]

Numerous healthcare stakeholders have expressed significant concerns about the MPFS's continuing trend of physician payment cuts. The American Medical Association (AMA) called for a congressional response to the proposed rule, stating that with "CMS estimating a fifth consecutive year of Medicare payment reductions—this time by 2.8%—it's evident that Congress must solve this problem."[17] The AMA added that "rural physicians and those treating underserved populations see this CMS warning as another reminder of the painful challenges they face in keeping their practices open and providing care. It's crucial that we ensure both continue."[18] Similarly, the Medical Group Management Association (MGMA) is concerned about the likely impact of the

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proposed conversion factor reduction, maintaining that this reduction causes significant concern for medical groups, as Medicare reimbursement rates are starting to undermine physician practices' sustainability.[19] Similar to the AMA, MGMA called on Congress to "pass the Strengthening Medicare for Patients and Providers Act to implement an annual inflation-based physician payment update tied to the Medicare Economic Index, and modernize Medicare's antiquated budget neutrality policies by enacting the Provider Reimbursement Stability Act."[20]

The Medicare Sustainable Growth Rate (SGR) was created by the *Balanced Budget Act of 1993* to (1) ensure patient access to physician services and (2) predictably control federal spending on Medicare Part B.[21] Under the SGR formula, if physician costs exceeded target expenditures, payments would be cut.[22] The SGR formula indicated downward adjustments to the MPFS every year since 2002. However, in what became a ritual, annual response to intense pressure from providers and advocates for the Medicare population, Congress consistently intervened and stepped in at the last moment to override the mandated decreases to the MPFS, typically replacing scheduled cuts with increases in payment. The SGR had many inefficiencies, such as: (1) making physician payments uncertain on a year-to-year basis; (2) disregarding group and individual performance; (3) distracting Congress from other legislative priorities; and (4) deferring actual improvements to the program.[23] In an effort to fix these problems and inefficiencies, CMS replaced the SGR formula in 2015 with scheduled updates to the MPFS.[24]

The last few years of threatened Medicare physician payment cuts and subsequent congressional intervention are beginning to mirror the issues encountered with the SGR formula. MACRA was supposed to alleviate the issues encountered with the SGR formula, but it has largely failed to do so. As a result, a number of federal legislators have called for another overhaul of physician payment updates. Two bills are currently being considered by Congress:

- The *Strengthening Medicare for Patients & Providers Act* would tie annual physician payment updates to the Medicare Economic Index (MEI), an index that accounts for inflation, the costs of running a practice, increases in office rent, professional liability insurance premiums, and employee wages.[25]
- The *Provider Reimbursement Stability Act* would reform the MPFS budget neutrality policies by (1) raising the budget neutrality threshold from $20 million to $53 million in 2025, and increasing the threshold every five years by the MEI, beginning in 2030; (2) requiring CMS to analyze utilization estimates compared to actual utilization by September 1st of each year; (3) mandating that CMS update the direct cost inputs for practice expense relative value units (RVUs) of staff wage rates, medical supplies, and equipment at least every five years; and (4) limiting the increases/decreases to the conversion factor by no more than 2.5% every year.[26]

While other reforms may still be necessary, these bills have gained bipartisan support on Capitol Hill, as well as support from the physician community.[27] However, it is unlikely that any bill will be passed this year given the presidential election (a notoriously hard time to pass bipartisan legislation), likely delaying any wholesale changes to the MPFS for at least another year.

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