

## Legislative Summary: Provider Reimbursement Stability Act

**Section 1: Short Title:** The Provider Reimbursement Stability Act of 2025

**Section 2: Updating the Budget Neutrality Threshold (Pgs. 1-3).** This provision would change the Medicare Physician Fee Schedule (MPFS) threshold requiring the Secretary of HHS to apply budget neutrality from \$20 million to \$54.3 million. Starting in 2032 and not less often than every 5 years, the threshold would be updated by the cumulative increase in the Medicare Economic Index (MEI). By way of background, the \$20 million budget neutrality threshold was established in 1992 following enactment of OBRA 1989 and has not been updated since.

*Explanatory Math for the \$54.3 Million Budget Neutrality Threshold:* With respect to setting the threshold as a share of total MPFS spending, the \$20 million threshold in 1992 was equivalent to 0.06% of total MPFS allowed charges in that year. The regulatory impact table from the CY2026 MPFS proposed rule (Table 92) has total annual MPFS allowed charges at \$90.545 billion. To keep the threshold at 0.06% of total allowed charges, the legislation ultimately increased the threshold to \$54.3 million in 2027.

**Section 3. Budget Neutrality Corrections Relating to Estimated Utilization (Pgs. 3-7).** This provision would require the Secretary to revise spending estimates and budget neutrality adjustments based on actual after-the-fact utilization rates derived from claims data. The provision would **only** affect budget neutrality adjustments for *newly unbundled codes* where CMS has to estimate utilization—not changes to rates where CMS has historical utilization data for either an existing code or a set of codes, or where utilization crosswalks from existing codes are used for new codes. In addition, the requirement for CMS to compare the utilization estimate to actual claims data only applies when the newly unbundled code exceeds 0.1% of the total estimated expenditures.

*Example:* CMS makes a cost and utilization estimate (that exceeds 0.1% of total estimated expenditures) plus a budget neutrality adjustment for a *newly unbundled* code in 2027 to take effect in 2028. The newly unbundled code and any associated budget neutrality adjustments based off the utilization estimate takes effect on January 1, 2028. This provision of the bill would require CMS to compare the initial utilization estimate for the newly unbundled code against 12-months of actual claims data available as of September 1, 2029, as well as make a *prospective* adjustment (e.g., either positive or negative) in the MPFS Conversion Factor for 2030 to ensure any over or underpayment from 2028 is not carried forward into future rates. No action would be taken to recoup or repay any difference in spending for 2028 or 2029. In other words, this section does not authorize a “claw back” of dollars. Instead, it only makes a *prospective* adjustment to the MPFS Conversion Factor based on a review of actual claims data for the newly unbundled code that had an initial cost estimate.

**Section 4. Timely Updates to Direct Costs Used to Calculate Practice Expense RVUs (Pgs. 7-9).** The direct cost inputs for practice expense RVUs include clinical wage rates, prices of medical supplies, and prices of equipment. As a result, this provision would require CMS to update the wage rates for clinical labor, as well as prices of equipment and medical supplies, simultaneously no less often than every 5 years. The Secretary of Health and Human Services is

also required to consult with relevant stakeholders, including physician specialty societies, when making these updates to the direct cost inputs for practice expense RVUs.

By way of background, CMS did not update supply and equipment prices from 2005-2019 and clinical staff wage rates from 2002-2022. The length of time between updates made price changes more significant than if prices were updated more frequently, which creates larger swings in payment than if these figures were more consistently, and simultaneously, updated.

**Section 5: Limitation on Year-to-Year Conversion Factor Variance (Pgs. 9-10).** Starting in 2027, this provision requires the Secretary to limit positive or negative increases to the MPFS conversion factor to no greater than 2.5% each year. The policy goal is to provide stability for the MPFS by removing relatively large and abrupt changes in the conversion factor calculations, such as those that may be due to large budget neutrality adjustments. The intent is for any policy that increases or decreases the conversion factor by 2.5% to continue in subsequent years. Of note, payment increases established by legislation would be exempt from this cap on the conversion factor. In other words, the statutorily mandated 0.25% increase for the Merit-based Incentive Payment System (MIPS) and 0.75% increase for Advanced Alternative Payment Models that began in 2026 per the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), as well as any potential, forthcoming increase associated with an inflationary update tied to the MEI, would be excluded from the cap.