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CY 2025 Outpatient Prospective Payment System and Ambulatory Surgery Center Payment System Final Rule

The Centers for Medicare and Medicaid Services (CMS) recently issued the Calendar Year (CY) 2025 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule. While the rule does include a slightly higher rate increase than originally proposed, it falls short of what the Medicare Payment Advisory Committee (MedPAC) recently recommended. Industry groups have also expressed concern with some other provisions of the final rule.

KEY TAKEAWAYS

- *Rate increase of 2.9% for OPPS and ASC (before quality reporting penalties or sequestration) – up from the proposed 2.6% bump*
- *One procedure (22848) will be removed from the Inpatient Only list.*
- *22 procedures added to the ASC Covered Procedures List, of which 19 are dental services*
- *Enhanced Conditions of Participation for hospitals providing OB services*
- *No requirement for ASC's to report costs, but CMS is exploring less burdensome methods to obtaining ASC cost information*

Payment Rate

Most notably, the rule includes an increase of 2.9% for both the OPPS and ASC payment rates, which is slightly higher than the 2.6% increase reflected in the proposed rule. This rate is based on a market basket increase of 3.4%, reduced by a 0.5 productivity adjustment. The payment rate will be reduced by 2% for hospitals and ASCs that fail to comply with applicable quality reporting requirements. Accordingly, the **OPPS conversion factor for 2025 is $89.169** (or $87.439 for hospitals that fail to meet OQR requirements), and the

ASC conversion factor is $54.895 (or $53.828 for ASCs that do not meet the quality reporting requirements). CMS estimates that the rate increases and other budget neutrality adjustments, including estimated changes in enrollment, utilization, and case mix, will result in an aggregate payment increase of $4.7 billion from 2024 OPPS payments, and an increase of $240 million from 2024 ASC payments.

As a result of the OPPS rate increase and other budget neutrality adjustments, CMS estimates that both urban and rural hospitals will see an increase in payments of around 3.2%. Nonteaching hospitals are expected to yield a 3.3% increase, while minor teaching hospitals and major teaching hospitals are anticipated to experience 3.5% and 2.7% increases, respectively.

CMS estimates that the overall impact of the ASC payment updates will be similar across surgical specialties, with GI services being slightly higher than the others, as shown below:

Surgical Specialty	Estimated Payment Increase
Musculoskeletal	3%
Gastrointestinal	5%
Nervous System	3%
Genitourinary	3%
Eye	3%
Cardiovascular	3%

Derived from Table 202 in the CY 2025 Medicare Hospital OPPS and ASC Payment System Final Rule.

However, there is expected to be variation among specific procedures. The rule includes a table with selected procedures, with estimated payment increases ranging from +7% to -8%.

Selected Procedures	Short Description	Estimated Payment Increase
43239	Egd biopsy single/multiple	7%
C9740	Cysto impl 4 or more	7%
0275T	Perq lamot/lam lumbar	5%
63685	Ins/rplc spi npg/rcvr pocket	5%
15823	Revision of upper eyelid	4%
27279	Arthrd si jt perq/min nvas	4%
29827	Sho arthrs srg rt8tr cuf rpr	4%
36902	Intro cath dialysis circuit	4%
45380	Colonoscopy and biopsy	4%
45385	Colonoscopy w/lesion removal	4%
62323	Njx interlaminar lmbr/sac	4%
64561	Implant neuroelectrodes	4%
64590	Ins/rpl prph sac/gstr npg/r	4%
64721	Carpal tunnel surgery	4%
G0105	Colorectal scrn; hi risk ind	4%

Selected Procedures	Short Description	Estimated Payment Increase
27130	Total hip arthroplasty	3%
27447	Total knee arthroplasty	3%
63650	Implant neuroelectrodes	3%
64635	Destroy lumb/sac facet jnt	3%
66982	Xcapsl ctrc rmvl cplx wo ecp	3%
66984	Xcapsl ctrc rmvl w/o ecp	3%
G0121	Colon ca scrn not hi rsk ind	3%
27446	Revision of knee joint	2%
64628	Trml dstrj ios bvn 1st 2 l/s	2%
65820	Relieve inner eye pressure	2%
64483	Njx aa&/strd tfrm epi l/s 1	1%
64493	Inj paravert f jnt l/s 1 lev	1%
66991	Xcapsl ctrc rmvl insj 1+	1%
66821	After cataract laser surgery	-2%
0784T	Ins/rplmt eltrd ra spi nstim	-8%

Derived from Table 203 in the CY 2025 Medicare Hospital OPPS and ASC Payment System Final Rule.

In its March 2024 *Report to the Congress: Medicare Payment Policy*, MedPAC noted that fee-for-service (FFS) Medicare payments to hospitals were lower than hospitals' costs in 2022. This was due to a variety of factors, including reinstatement of the 2% sequestration (discussed further below) and declining uncompensated care payments. Combined with higher-than-expected inflation, Medicare margins for hospitals declined to a record low in 2022. Outpatient costs per Medicare FFS Part B beneficiary increased by 8.1%, while OPPS payments per beneficiary increased by only 6.9%. To combat this, MedPAC recommended that Congress update the Medicare base payment rates for hospitals, by the amount specified in current law plus 1.5%. Of course, the rule issued by CMS must adhere to current law, and therefore does not reflect MedPAC's recommended increase – that could only be implemented through legislative action.

Sequestration Impact

It should be noted that the payment rates reflected in the OPPS/ASC final rule are prior to any reduction for sequestration. Sequestration is a required across-the-board spending cut resulting from three budget enforcement rules:

- The Statutory Pay-As-You-Go Act of 2010 (PAYGO);
- The Budget Control Act of 2011 (BCA); and
- The Fiscal Responsibility Act of 2023 (FRA).

Only the sequestration stemming from the BCA is currently in effect, and it will impact Medicare payments through fiscal year 2032. Under this law, cuts to Medicare benefit payments cannot exceed 2%. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

PAYGO requires spending cuts across the federal government if legislation enacted in a year results in an increase in projected budget deficits. Subsequent legislation has postponed these spending cuts through the end of 2024. Without additional Congressional action, PAYGO could be triggered in 2025. PAYGO cuts to Medicare benefit payments would be capped at 4%. However, neither PAYGO nor the BCA include details on how the two sequesters would be implemented together.

The FRA sequester applies to discretionary funding and can be triggered if applicable budget enforcement rules are broken. Since the Medicare program is funded by both mandatory and discretionary spending, any FRA sequester could impact Medicare. However, this sequester would impact only discretionary components of the Medicare program, such as administration and fraud investigation activities. Payments to providers for services rendered to Medicare beneficiaries would not be impacted.

Changes to IPO & ASC Covered Procedures Lists

Although the proposed rule did not remove any services from the Inpatient Only (IPO) list for 2025, the final rule did remove one CPT code – 22848 (Pelvic fixation other than sacrum) – from the IPO list and reassign it to status indicator “N” (Items and services Packaged Into APC Rates) since it is an add-on code and will always be packaged. CMS did finalize adding three services to the IPO list, as proposed. These codes, all of which relate to liver allograft procedures, were newly created, and it was determined that they require a hospital inpatient admission or stay.

The rule would add two medical and nineteen dental surgical procedures to the ASC Covered Procedures List (CPL) for 2025, after CMS determined that doing so would not pose a significant risk to the safety of Medicare patients. The medical procedures include two services related to treatment of rotator cuff tears. Two other services related to insertion, removal, and replacement of certain pacemakers that had been proposed to be added to the ASC CPL were not included in the final rule, due to previous CMS guidance that excludes contractors from paying claims for leadless pacemakers when the service is performed in an ASC setting. The dental surgical procedures added to the ASC CPL include three (D7320, D7321, and D7471) that were not on the list originally proposed.

Obstetrical Services

The rule would add new Conditions of Participation (CoPs) for hospitals and critical access hospitals (CAH) providing obstetrical (OB) services. This would include several new requirements, including:

- Maternal quality assessment and performance improvement;
- Maternal health data reporting;
- Baseline standards for the organization, staffing, and delivery of care with obstetrical units; and
- Staff training on evidence-based practices.

The rule finalizes proposed provisions that would require OB units to be supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or doctor of medicine or osteopathy. Further, the hospital must maintain a roster of OB practitioners, specifying the privileges of each practitioner. Also, facilities offering OB services would be required to have basic equipment, including a call-in system (e.g., call button), cardiac monitor, and fetal doppler monitor, at the facility and readily available to meet the needs of OB patients in accordance with the scope, volume, and complexity of services offered by the facility. Such equipment may be located in every labor and delivery room or on "crash carts" that are readily available, depending on the volume and acuity of OB patients. OB services must have protocols, consistent with evidence-based guidelines, and have readily available supplies and equipment for OB emergencies, complications, and immediate post-delivery care.

In response to many comments CMS received requesting sufficient time for facilities to meet the new CoP requirements, the final rule makes some modifications to the proposal. While the proposed rule included an *annual* staff training requirement, the final rule requires that relevant new staff receive initial training, and hospitals must identify which staff must complete training every *two* years. Additionally, the final rule adopts an approach that phases the CoP requirements in over a two-year period, as summarized below:

	Deadline	Required Provisions
Phase 1	July 1, 2025	• Emergency services' readiness (hospitals & CAHs) • Transfer protocols (hospitals only)
Phase 2	January 1, 2026	• Organization, staffing, and delivery of services (hospitals & CAHs)
Phase 3	January 1, 2027	• OB staff training (hospitals & CAHs) • QAPI program for OB services (hospitals & CAHs)

CMS estimates that the cost to comply with the requirements will be $423 million annually – around $67,000 per hospital/CAH – for a total of $4.23 billion over a ten-year period.

Mental Health Services

Partial Hospitalization and Intensive Outpatient Programs

In light of heightened awareness of the need for mental health services, CMS established a payment structure for partial hospitalization services and intensive outpatient services effective beginning in 2024. CMS describes a partial hospitalization program (PHP) as an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for patients with acute mental illness, including substance use disorders. A PHP may be provided by a hospital or a community mental health center (CMHC) as a distinct and organized intensive ambulatory treatment service, with less than 24-hour daily care, in a location other than the patient's home or an inpatient or residential setting. A physician must determine that each PHP patient requires a minimum of 20 hours of services each week, with redetermination occurring at least monthly.

An intensive outpatient program (IOP) is similar to a PHP but has a lower threshold – a minimum of 9 hours per week – for which a physician determines that a patient needs psychiatric services. IOP services may be provided by a hospital, a CMHC, a federally qualified health center (FQHC), or a rural health clinic (RHC) as a distinct and organized intensive ambulatory treatment service, with less than 24-hour daily care, in a location other than the patient's home or an inpatient or residential setting. A physician must redetermine the need for IOP services at least every other month.

The payment structure for 2025 is consistent with that utilized in 2024, with separate per diem amounts for IOP and PHP services provided by hospitals or CMHCs. The rates are based on either three services per day, or four or more services per day. CMS expects days with fewer than three services to be very infrequent. The rates for 2025 are as follows:

		3 Services per Day		4+ services per day	
		APC	Payment Rate	APC	Payment Rate
PHP	CMHC	5853	$ 112.59	5854	$ 170.37
	Hospital	5863	$ 272.46	5864	$ 413.50
IOP	CMHC	5851	$ 112.59	5852	$ 170.37
	Hospital	5861	$ 272.46	5862	$ 413.50

Derived from Table 136 in the CY 2025 Medicare Hospital OPPS and ASC Payment System Final Rule.

Other Provisions

Prior Authorization

The rule finalizes provisions that would align certain Medicare fee-for-service prior authorization review requirements to the rules already in place for certain other payers, including Medicare Advantage plans, under the CMS Interoperability and Prior Authorization final rule. This would reduce the timeframe for standard review requests from ten business days to seven calendar days. There is no change to the required timeframe for expedited review decisions, which is currently two business days.

Quality Reporting Programs

As previously noted, the final rule applies a 2% reduction in the OPPS and ASC payment rates for failure to meet quality reporting requirements. CMS is implementing certain cross-program modifications to the quality reporting programs for hospital outpatient departments, rural emergency hospitals (REHs), and ASCs. The revisions include the adoption of the following measures in all three programs:

Measure	Voluntary Reporting Period	First Mandatory Reporting Period
Hospital / Facility Commitment to Health Equity	N/A	2025 (for 2027 payment)
Screening for Social Drivers of Health (SDOH)	2025	2026 (for 2028 payment)
Screen Positive Rate for SDOH	2025	2026 (for 2028 payment)

Additionally, CMS finalized the proposed modifications to the Immediate Measure Removal policy for adopted hospital outpatient and ASC quality reporting program measures beginning in 2025.

Specific to the Hospital Outpatient Quality Reporting Program, CMS implemented several changes, including the addition of a new measure related to a patient's understanding of key information after an outpatient surgery or procedure. However, rather than being required in 2025 as originally proposed, this will now begin with voluntary reporting for the 2026 reporting period before becoming mandatory for the 2027 reporting period for 2029 payment determination. Two current measures (MRI Lumbar Spine for Low Back Pain and Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery) will be removed, effective for the 2025 reporting period. Electronic health record technology will be required to be certified to all electronic clinical quality measures available to report beginning with the 2025 reporting period. Finally, hospitals will be required to publicly report the median time from emergency department (ED) arrival to discharge for psychiatric / mental health patients discharged from the ED, beginning in 2025.

The Rural Emergency Hospital Quality Reporting Program will be modified to extend the reporting period for the Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery measure from one year to two years beginning with the 2027 program determination, and to establish when REHs would be required to report data under the quality reporting program after converting to an REH. These changes are consistent

with what was reflected in the proposed rule.

No specific changes to the ASC Quality Reporting program were included in either the proposed rule or the final rule, other than the applicable cross-program measures noted above.

Continuous Eligibility in Medicaid and CHIP

To codify the requirements promulgated in the Continuing Appropriations Act (2023) for states to provide twelve months of continuous eligibility in Medicaid and the children's health insurance program (CHIP) to children under the age of 19, the final rule removes certain options that previously allowed for a shorter period of continuous coverage for certain enrollees. Children can no longer be disenrolled from CHIP during a continuous eligibility period for failing to pay premiums.

ASC Cost Data

Notably, the rule did not contain any cost reporting requirements for ASCs. In its March 2024 *Report to the Congress: Medicare Payment Policy*, MedPAC stressed that the lack of cost reporting makes it impossible to evaluate the Medicare payment rate for ASCs in relation to their costs. CMS acknowledges that cost data submission requirements could place additional administrative burden on most ASCs, and therefore did not implement any cost reporting requirements. Instead, CMS sought public comment on methods that would mitigate the burden of reporting costs on ASCs while also collecting enough data to reliably use such data in the determination of ASC costs. This is an area that likely will be considered in future rulemaking.

Industry Response

The American Hospital Association (AHA) released a statement noting that "the final increase of less than 3% for outpatient hospital services will make the provision of care, investments in the health care workforce, and addressing new challenges, such as cybersecurity threats, more difficult." Further, while the AHA supports the "goals of improving maternal health outcomes and reducing inequities in maternal care," they believe "a less punitive and more collaborative and flexible approach would be more effective."

The Ambulatory Surgery Center Association (ASCA) also weighed in. In particular, the ASCA expressed disappointment that "CMS declined to add any of the surgical procedures requested by ASCA to the ASC Covered Procedures List for 2025." As it relates to the new quality reporting measures, ASCA's Chief Executive Officer stated that "this rulemaking does not make clear how the measures will address the disparities that exist or how CMS will support the facilities required to collect this information." He further noted that "if these measures had been tested in the ASC setting before being proposed, let alone adopted, the Agency would have realized that the ASC setting is not the proper site of service to obtain this data."

JTaylor's healthcare consulting team includes experienced professionals who focus on strategy and operations for all types of providers. If you are interested in finding out how the CY 2025 OPPS/ASC Final Rule may impact reimbursement for your facility, we can help. Our team can also support you from a strategic perspective as you determine how to respond to the upcoming changes in Medicare reimbursement. To find out more or to contact a member of our team, please visit our website.

Resources:

- Fact Sheet: CY 2025 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1809-FC)
- Final Rule: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program, etc.
- *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission, March 2024.
- *AHA Statement on CY 2025 OPPS Final Rule*, American Hospital Association (1 November 2024).
- *CMS Releases 2025 Final Payment Rule*, Ambulatory Surgery Center Association (1 November 2024)