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CY 2025 Outpatient Prospective Payment System and Ambulatory Surgery Center Payment System Proposed 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 Proposed Rule. While the proposal does include a rate increase, 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 proposed rule.

KEY TAKEAWAYS

- *Proposed rate increase of 2.6% for OPPS and ASC (before quality reporting penalties or sequestration)*
- *No procedures will be removed from the Inpatient Only list*
- *20 procedures added to the ASC Covered Procedures List, of which 16 are dental services*
- *Enhanced Conditions of Participation for hospitals providing OB services*
- *No requirement for ASC's to report costs, but CMS is seeking public comments to explore less burdensome methods to obtaining ASC cost information*

Payment Rate

Most notably, the proposed rule includes an increase of 2.6% for both the OPPS and ASC payment rates. This rate is based on a market basket increase of 3%, reduced by 0.4 percentage point as a result of the 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 proposed **OPPS conversion factor for 2024**

is $89.379 (or $87.636 for hospitals that fail to meet OQR requirements), and the proposed **ASC conversion factor is $54.675** (or $53.609 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 $5.2 billion from 2024 OPPS payments, and an increase of $202 million from 2024 ASC payments.

As a result of the OPPS rate increase and other budget neutrality adjustments, CMS estimates that urban hospitals will see an increase in payments of around 2.4% while rural hospitals will experience a 2.8% increase. Nonteaching hospitals are expected to yield a 2.5% increase, while minor teaching hospitals and major teaching hospitals are anticipated to experience 2.7% and 2.1% 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	2%
Gastrointestinal	3%
Nervous System	2%
Genitourinary	2%
Eye	2%
Cardiovascular	2%

Derived from Table 132 in the CY 2025 Medicare Hospital OPPS and ASC Payment System Proposed Rule.

However, there is expected to be variation among specific procedures. The proposed rule includes a table with selected procedures, with estimated payment increases ranging from an of 6% to -4%.

Selected Procedures	Short Description	Estimated Payment Increase
43239	Egd biopsy single/multiple	6%
C9740	Cysto impl 4 or more	6%
62323	Njx interlaminar lmbr/sac	5%
63685	Ins/rplc spi npg/rcvr pocket	4%
36902	Intro cath dialysis circuit	4%
64561	Implant neuroelectrodes	4%
0275T	Perq lamot/lam lumbar	4%
45380	Colonoscopy and biopsy	3%
45385	Colonoscopy w/lesion removal	3%
63650	Implant neuroelectrodes	3%
64635	Destroy lumb/sac facet jnt	3%
29827	Sho arthrs srg rt8tr cuf rpr	3%
G0105	Colorectal scrn; hi risk ind	3%
G0121	Colon ca scrn not hi rsk ind	3%
15823	Revision of upper eyelid	3%

Selected Procedures	Short Description	Estimated Payment Increase
64721	Carpal tunnel surgery	3%
27279	Arthrd si jt perq/min nvas	3%
66984	Xcapsl ctrc rmvl w/o ecp	2%
27447	Total knee arthroplasty	2%
27130	Total hip arthroplasty	2%
64483	Njx aa&/strd tfrm epi l/s 1	2%
64590	Ins/rpl prph sac/gstr npg/r	2%
66982	Xcapsl ctrc rmvl cplx wo ecp	2%
64493	Inj paravert f jnt l/s 1 lev	2%
66821	After cataract laser surgery	2%
65820	Relieve inner eye pressure	2%
27446	Revision of knee joint	2%
64628	Trml dstrj ios bvn 1st 2 l/s	1%
66991	Xcapsl ctrc rmvl insj 1+	0%
0784T	Ins/rplmt eltrd ra spi nstim	-4%

Derived from Table 133 in the CY 2025 Medicare Hospital OPPS and ASC Payment System Proposed 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 proposed 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

CMS is not proposing to remove any services from the Inpatient Only (IPO) list for 2025. However, three services for which codes were newly created for 2025 are proposed to be added to the IPO list since it was determined that they require a hospital inpatient admission or stay. All three of the newly added services relate to liver allograft procedures.

The proposed rule would add four medical and sixteen dental surgical procedures to the ASC Covered Procedures List 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 and two services related to insertion, removal, and replacement of certain pacemakers.

Obstetrical Services

The proposed 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
- Annual staff training on evidence-based practices.

The proposed rule contains 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, labor and delivery room areas would be required to have basic resuscitation equipment readily available. 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.

CMS estimates that the annual cost to comply with the proposed requirements would be around $446 million in aggregate. The average annual cost per hospital is expected to be $70,671.

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 reflected in the proposed rule 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 3 services per day, or 4 or more services per day. CMS expects days with fewer than 3 services to be very infrequent. The rates proposed for 2025 are as follows:

		3 Services per Day		4+ services per day	
		APC	Payment Rate	APC	Payment Rate
PHP	CMHC	5853	$ 118.69	5854	$ 164.84
	Hospital	5863	$ 279.97	5864	$ 428.39
IOP	CMHC	5851	$ 118.69	5852	$ 164.84
	Hospital	5861	$ 279.97	5862	$ 428.39

Other Provisions

Prior Authorization

The proposed rule contains 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. However, CMS is not currently proposing to change the required timeframe for expedited review decisions, which is currently two business days.

Quality Reporting Programs

As previously noted, the Proposed Rule reflects a 2% reduction in the OPPS and ASC payment rates for failure to meet quality reporting requirements. CMS is proposing certain cross-program modifications to the quality reporting programs for hospital outpatient departments, rural emergency hospitals (REHs), and ASCs. The proposed 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 proposes to modify 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 proposes several changes, including the addition of a new measure related to a patient's understanding of key information after an outpatient surgery or procedure, which would be required beginning in the 2025 reporting period. Two current measures would be removed, effective for the 2025 reporting period. Electronic health record technology would be required to be certified to all electronic clinical quality measures available to report beginning with the 2025 reporting period. Finally, hospitals would 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 would 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.

No specific changes to the ASC Quality Reporting program are included in the proposed rule, other than the cross-program measures noted above. CMS is, however, requesting public comment on potential frameworks for specialty focused reporting.

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 proposed rule removes certain options that previously allowed for a shorter period of continuous coverage for certain enrollees. Under the proposal, children could not be disenrolled from CHIP during a continuous eligibility period for failing to pay premiums.

ASC Cost Data

Notably, the proposed rule does 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. Specifically, MedPAC "reiterate[s] our long-standing recommendation that Congress require ASCs to submit cost data." In the proposed rule, CMS acknowledges that cost data submission requirements could "please additional administrative burden on most ASCs." Rather than proposing any reporting requirements, CMS instead "seeks

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."

Industry Response

The American Hospital Association (AHA) released a statement noting that "hospitals' and health systems' ability to continue caring for patients and providing essential services for their communities may be in jeopardy." 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 is far superior."

The Ambulatory Surgery Center Association (ASCA) also weighed in. In particular, the ASCA applauded CMS's proposal to continue aligning the ASC update factor with that applied to HOPD payments, honoring the two-year extension (through 2025) added to the five-year interim period that was codified in the CY 2024 OPPS/ASC Payment System Final Rule. This will allow CMS to utilize claims data from 2023 and 2024 to analyze whether application of the productivity-adjusted hospital market basket update to the ASC payment system impacted migration of services from hospital settings to ASCs.

Comments relating to the proposed rule may be submitted until September 9, 2024.

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 Proposed 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 Proposed Rule (CMS 1809-P)
- Proposed 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; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; etc.
- *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission, March 2024.
- *AHA Statement on CY 2025 OPPS Proposed Rule*, American Hospital Association (10 July 2024).
- *CMS Releases 2025 Proposed Payment Rule*, Ambulatory Surgery Center Association (10 July 2024)