CHAMBER HILL

INSIGHTS

Changes under the CY 2025 Hospital Outpatient PPS Final Rule

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On November 1, 2024, the Centers for Medicare and Medicaid Services (CMS) released their hospital outpatient and ambulatory surgery center (ASC) payment final rule for Calendar Year (CY) 2025. CMS also released a fact sheet.

HOSPITAL PAYMENT CHANGES

For CY 2025, CMS is increasing outpatient payment rates by 2.9%. This includes a 3.4% increase coupled with a 0.5% productivity adjustment. This equates to a $4.7 billion increase in payment for 2025. In addition, CMS is continuing the 2.0% reduction for all hospitals that fail to meet quality reporting requirements. The CY 2025 outpatient conversion factor is set at $89.17 (it was $87.3 last year).

All wage index updates are consistent with the Inpatient Prospective Payment System updates. This will lead to a 0.1% increase for urban hospital wage index payments next year, and a 0.9% increase for rural hospital wage index payments. In accordance with statute, the Outpatient Prospective Payment System (OPPS) rule does continue paying Frontier Hospitals at a wage index of 1.0. Final wage index amounts by hospital can be found here: https://www.cms.gov/files/zip/fy-2025-ipps-final-wage-index-public-use-files.zip

CMS also listed all new Healthcare Common Procedure Coding System (HCPCS) codes enacted this year (they are adopted quarterly). - The codes range from new injection codes (30) to new supply codes to lab testing codes. The new codes are listed starting on Page 213 of the proposed rule PDF.

Panelists raised various issues related to CE. Panelists first pointed out why states are choosing to expand eligibility, pointing to the bipartisan desire for children to have a good start in life and how access to health care leads to these children being successful adults. Emma Sandoe walked through how Oregon's roll out is going and barriers they faced such as cost and some conflicts due to households with multiple kids having different renewal dates.

Commissioner questions focused on barriers to rolling out CE, interest in additional research desired into long-term outcomes, and how to partner with Medicaid plans on CE. MACPAC staff will be doing additional research on these questions and presenting them at future meetings.

Access to Non-Opioid Treatments for Pain Relief

CMS is providing separate payments for certain non-opioid drugs and medical devices for pain relief in the hospital outpatient department (HOPD) from January 1, 2025, through December 31, 2027. This is based on CMS' determination that these treatments reduce opioid usage postoperatively. This policy supports the agency's behavioral health goals of reducing opioid overdoses and promoting effective pain management. Finalized qualifying products are:

Brand Name	HCPCS	Long Descriptor	Meets Requirements
Exparel	J0666 (Previously C9290)	Injection, bupivacaine liposome, 1mg	Yes
Omidria	J1097	Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	Yes
Dextenza232	J1096	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg	Yes
Xaracoll	C9089	Bupivacaine, collagen-matrix implant, 1 mg	Yes
Zynrelef	C9088	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg	Yes. Effective April 1, 2025
Ketorolac tromethamine Injection	J1885	Injection, ketorolac tromethamine, per 15 mg	Yes
ON-Q Pump	(C98X4/ C9804)	Elastomeric infusion pump (e.g., ON-Q* Pump with Bolus), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post- surgical pain relief in accordance with Section 4135 of the CAA, 2023)	Yes
SPRINT Peripheral Nerve Stimulator System	(C9807)	Nerve stimulator, percutaneous, peripheral (e.g., SPRINT Peripheral Nerve Stimulation System), including electrode and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	Yes

Cryo Nerve Block Therapy	(C9808)	Nerve cryoablation probe (e.g., cryoICE, cryoSPHERE, cryoSPHERE MAX, cryoICE cryoSPHERE, cryoICE Cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post- surgical pain relief in accordance with Section 4135 of the CAA, 2023)	Yes
ambIT Electronic Infusion Pump	(C9806)	Rotary peristaltic infusion pump (e.g., ambIT Pump), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	Yes
Iovera System	(C9809)	Cryoablation needle (e.g., iovera System), including needle/tip and all disposable system components, non- opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	Yes

Source: CMS, Table 158

Partial Hospitalization Program (PHP)

The PHP is an intensive, structured outpatient program provided as an alternative to psychiatric hospitalization, consisting of a specified group of mental health services paid on a per diem basis for a minimum of 20 hours of PHP services per week under the OPPS, based on PHP per diem costs. For CY 2025, CMS is maintaining the calculation of both hospital outpatient and Community Mental Health Center (CMHC) PHP payment rates. If four or more services are provided in a single day, these mental health services would be paid through composite APC 8010.

Supervision by Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists of Cardiac, Intensive Cardiac and Pulmonary Rehabilitation Program Services

The Balanced Budget Act of 2018 allows nurse practitioners, physician assistants and clinical nurse specialists to supervise cardiac programs, intensive cardiac programs, and pulmonary rehabilitation programs furnished to outpatients. Prior to this, only physicians could supervise services in these

programs furnished to outpatients. Prior to this, only physicians could supervise services in these programs. The final rule allows this policy to continue until December 31, 2025

Inpatient Only (IPO) List

CMS moved 3 procedures to the IPO list and removed 1 for 2025. They are as follows:

CY 2025 CPT Code	CY 2025 Long Descriptor	Action	CY 2025 Proposed Status Indicator
0894T	Cannulation of the liver allograft in preparation for connection to the normothermic perfusion device and decannulation of the liver allograft following normothermic perfusion	Add to the IPO list	C
0895T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; initial 4 hours of monitoring time, including hourly physiological and laboratory assessments	Add to the IPO list	C
0896T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; each additional hour, including physiological and laboratory assessments	Add to the IPO list	C
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum	Remove from the IPO list	N

MATERNAL HEALTH

CMS proposed new Conditions of Participation (CoPs) for OB services for hospitals and Critical Access Hospitals (CAHs), including new requirements for maternal quality assessment and performance improvement (QAPI), baseline standards for the organization, staffing, and delivery of OB care, and staff training on evidence-based maternal health practices. Given the scope of these changes, CMS will be using a phased-in approach for these requirements.

Organization and Staffing

CMS is finalizing a requirement that OB services be well organized and provided in accordance with nationally recognized acceptable standards of practice for the health care (including physical and

behavioral health) of pregnant, birthing, and postpartum patients. CMS is also finalizing a requirement that OB patient care units are supervised by an individual with the necessary education and training, such as an experienced registered nurse (RN), certified midwife, nurse practitioner, physician assistant, or Doctor of Medicine or osteopathy.

Delivery of Service

CMS is finalizing a requirement that basic equipment for treating OB cases (including a call-in-system, cardiac monitor, and fetal doppler/monitor) be kept at the facility and be readily available for treating OB cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered by the facility, at a minimum. CMS noted that hospitals and CAHs could maintain these and other obstetrical emergency supplies in "crash carts," "obstetrical emergency carts/bags/boxes/kits,"[2] "OB hemorrhage carts,"[3] or other readily accessible methods for use when and where needed.

Staff Training

CMS is finalizing a requirement that hospitals and CAHs develop policies and procedures to ensure that relevant staff are trained on certain topics aimed at improving the delivery of maternal care, including evidence-based best practices and protocols to improve the delivery of maternal care within the facility. Staff to receive the training include 1) relevant new staff and 2) ongoing staff who must complete training every two years instead of annually. All staff training must be documented.

Quality Assessment and Performance Improvement (QAPI) Program

CMS is finalizing requirements that hospitals or CAHs providing OB services must use their QAPI programs to assess and improve health outcomes and disparities among OB patients on an ongoing basis. Specifically, at a minimum, the facility will have to:

1. Analyze data and quality indicators collected for the QAPI program by diverse subpopulations as identified by the facility among OB patients.
2. Measure, analyze, and track data, measures, and quality indicators on patient outcomes and disparities in processes of care, services and operations, and outcomes among obstetrical patients
3. Analyze and prioritize patient health outcomes and disparities, develop and implement actions to improve patient health outcomes and disparities, measure results, and track performance to ensure improvements are sustained when disparities exist among obstetrical patients.
4. Conduct at least one performance improvement project focused on improving health outcomes and disparities among the hospital's population(s) of obstetrical patients annually.

CMS is also finalizing a requirement that obstetrical services' leadership engage in OB QAPI activities. Lastly, CMS is finalizing a requirement that if a Maternal Mortality Review Committee (MMRC) is available at the state, Tribal, or local jurisdiction in which the facility is located, hospitals and CAHs that offer OB services must have a process for incorporating publicly available information and data from the MMRC into the hospital or CAH QAPI program.

Emergency Services' Readiness

CMS is finalizing a revised Emergency Services' CoP to improve facility readiness in caring for emergency services' patients, including pregnant, birthing, and postpartum women. Hospitals and CAHs must have protocols consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions. Additionally, applicable staff will be required to be trained aon these protocols and provisions annually and this training must be documented.

Transfer Protocols

CMS is finalizing the requirement for a hospital to have written policies and procedures for transferring patients under its care, which will include intra-hospital transfers of hospital inpatients to the appropriate level of care as needed to meet the patient's needs.

Implementation Phase-In

CMS is implementing these provisions in three phases over two years:

- Phase 1 requires facilities to comply with the following requirements six months following the effective date of the final rule:
    - Emergency services' readiness for hospitals and CAHs.
    - Transfer protocols for hospitals only.
- Phase 2 requires facilities to comply with the following requirements one year following the effective date of the final rule:
    - Organization, staffing, and delivery of services for hospitals and CAHs.
- Phase 3 requires facilities to comply with the following requirements two years following the effective date of the final rule:
    - OB staff training in hospitals and CAHs.
    - QAPI program for OB services in hospitals and CAHs.

CMS estimates the cost of compliance to be $446 million annually, and $4.46 billion/10 years. The agency expects the benefits of the policies to include reduced maternal morbidity and mortality.

HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

In 2009, CMS implemented a Hospital OQR program to measure data on the quality and efficiency of care received by Medicare beneficiaries. CMS is adopting 4 new measures and removing 2 from theits OQR program. There are also 2 measure modifications.

CMS proposes to add the following 4 new measures:

1. Hospital Commitment to Health Equity (HCHE): voluntary reporting in CY 2025 with mandatory reporting beginning in CY 2026.
2. Screening for Social Drivers of Health (SDOH): voluntary reporting in CY 2025 with mandatory reporting in CY 2026
3. Screen Positive Rate for SDOH: voluntary reporting in CY 2025 with mandatory reporting beginning in CY 2026.
4. Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM): Voluntary reporting in CY 2026 followed by mandatory reporting beginning in CY 2027.

CMS is removing the following measures:

1. MRI Lumbar Back Pain: This measure evaluates the percentage of magnetic resonance imaging (MRI) of the lumbar spine studies for low back pain performed in the outpatient setting where conservative therapy was not attempted prior to the MRI. CMS will remove the measure beginning in CY 2025.
2. Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery. CMS will remove the measure beginning in CY 2025.

CMS proposes to modify 2 measures:

1. Electronic Health Records Technology: CMS is adding a requirement that electronic health records be certified to all electronic clinical quality measures (eCQMs) available to report.
2. Median Time from Emergency Department (ED) Arrival to Discharge measure for psychiatric/mental health patients. CMS is revising this measure to require public reporting on Care Compare.

ADDITIONAL PROVISIONS

Add-On Payment for High-Cost Drugs Provided by the Indian Health Service (IHS)

Under current regulations, IHS andTribal hospitals are paid the Medicare outpatient hospital all-inclusive rate (AIR) for outpatient services. That bundle included all aspects of the hospital service, including drugs. However, CMS is concerned that Tribal hospitals are now providing higher-cost drugs along with more complex and expensive services, such as cancer-related services. Citing health equity and beneficiary access concerns, CMS will now pay an add-on payment to the AIR for certain high-cost drugs for Medicare beneficiaries who receive care at IHS or Tribal hospitals.

Coverage for Individuals formerly in the Custody of Penal Authorities

CMS narrows the definition of "custody" to no longer include individuals on parole, probation, or home detention and removes the presumption that Medicare is prohibited from paying for health care items or services furnished to these individuals. This aligns more closely with the Social Security Administration's criteria for determining incarceration status.

Hospital-Specific Impacts

To look at calculated final total payments, outlier payments, and other impacts from this rule listed by hospital, you can visit: https://www.cms.gov/files/zip/2025-nfrm-opps-facility-specific-impacts.zip

We trust you found this summary useful. Please reach out to us with any questions.