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Hospitals, ASCs, Physicians: Final CY25 Medicare Regs – Some Improvement, Some Disappointment, But Still Meeting Overall Expectations

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Key Takeaways: CMS largely met reimbursement and policy expectations with its CY25 final Medicare payment rules for hospital outpatient departments (HOPDs), ambulatory surgery centers (ASCs) and physician firms. This is despite the improvement, relative to the summer proposal, for HOPDs and ASCs with an estimated 3% increase in total Medicare spending and an even higher bump of 4.9% for for-profit HOPDs and despite the disappointment for physicians with a 2.93% reduction in aggregate Medicare spending. These payment changes, reflected in Friday's final rules, are largely a function of cost inputs and statutory decisions.

Medicare HOPD and ASC rate policy is largely set for the coming year with: 1) a 2.9% inflationary update to the conversion factor (aka the base rate), which largely drove the 3% rise in total Medicare spending, 2) expanded offering of services, 3) access to new breakthrough devices, and 4) potential for greater patient volumes. Yet, facilities will still likely cry that payments fail to keep up with past cost growth and likely demand that more procedures can be safely performed in these settings. We doubt these ongoing complaints will elicit a legislative response.

However, Medicare physician payment policies are not as settled and are likely to be revised in a few months. It is widely expected that Congress will mitigate the physician rate cuts in an FY25 government spending bill, given that these annual reductions stemming from expiring statutory provisions have become a must-pass bipartisan concern and routine healthcare extenders item. Yet, near term full relief is unlikely as we are skeptical Congress will enact the Medicare Patient Access and Practice Stabilization Act of 2024, which would increase physician payments in CY25 by 4.73%, more than offsetting the 2.93% cut. Rather, we presume it would heed past patterns and shrink the size of the anticipated reduction. We also expect Congress to extend again the various telehealth flexibilities set to expire at year-end.

CY25 Medicare Outpatient Prospective Payment System Rule

This lengthy final rule addresses a host of Medicare HOPD/ASC-related payment policies as well as other issues (Medicare coverage for formerly incarcerated individuals, new maternal health and safety standards, expanded access to intensive outpatient program rates, and continuous Medicaid/CHIP eligibility for children). Below we highlight the more impactful ones for HOPDs and ASCs. **Estimated Medicare total spending for HOPDs.** CMS thinks its final policies would boost overall Medicare spending by $4.7B to $87.7B, including beneficiary cost-sharing and changes in enrollment, utilization and case-mix. Most of this increase is driven by the statutory inflationary update with some contribution

Tenet Healthcare Corporation (THC)

Price:	$156.18
52-Week High:	$171.20
52-Week Low:	$52.08

HCA Holdings Inc (HCA)

Price:	$357.19
52-Week High:	$417.14
52-Week Low:	$226.44

Community Health Systems Inc (CYH)

Price:	$4.21
52-Week High:	$6.29
52-Week Low:	$2.28

Ardent Health Partners, Inc. (ARDT)

Price:	$17.70
52-Week High:	$20.72
52-Week Low:	$15.00

Surgery Partners Inc (SGRY)

Price:	$28.75
52-Week High:	$36.92
52-Week Low:	$22.25

RadNet Inc (RDNT)

Price:	$66.54
52-Week High:	$72.18
52-Week Low:	$28.27

US Physicalrapy Inc (USPH)

Price:	$81.46
52-Week High:	$113.63
52-Week Low:	$76.18

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from recalibrating procedural weights and wage index changes. This translates to a 3% estimated aggregate increase for HOPDs, 3.2% for urban or rural HOPDs as a group, and 4.9% for for-profit HOPDs.

Estimated Medicare total spending for ASCs. CMS projects that overall Medicare payments will rise by $308M to $7.4B, accounting for beneficiary cost-sharing and changes in enrollment, utilization and case-mix. By medical specialty, it tallies a total spending increase of 3% for ophthalmic, nervous, cardiovascular, and genitourinary system procedures, respectively, and 5% for digestive system procedures.

Inflationary update and conversion factors. CMS finalizes a net 2.9% inflationary increase to the conversion factor (i.e. base rate), reflecting the statutory formula of a 3.4% hospital inpatient market basket minus 0.5% productivity adjustment and affording a 30bp improvement over the proposal. There was no decision about how the agency will adjust ASC rates in CY26 or whether it will revert to a CPI-based inflationary formula. For CY25, the HOPD conversion factor will be $89.160 vs. Cy24's $87.382 and the ASC conversion factor will be $54.895 vs. CY24's $53.514.

Changes to the procedural lists in the ambulatory setting. CMS is continuing its systematic efforts to allow more procedures to be performed in cheaper ambulatory settings. Specifically, it added 19 dental procedures and 2 medical procedures to its ASC covered procedure list while permitting a pelvic fixation procedure in the HOPD. It also decided to only allow three liver allograft services be done inpatient.

Transitional pass-through (TPT) awards. CMS is approving eight out of the 14 applications received for TPT bonus payments, thereby allowing these ambulatory providers with additional reimbursement when procedures use these eligible new and costly devices. The eight awardees involved FDA breakthrough devices like **BSX's** Agent paclitaxel-coated balloon catheter and **MDT's** Symplicity Spyral renal denervation system. CMS also maintained TPT status for 11 other eligible devices. The agency estimates $318M in device-related TPT spending for CY25, eclipsing the projected $10M in TPT spending for eligible drugs and biologics for the coming year.

CY25 Medicare Physician Fee Schedule

CMS' extensive final rule discusses many reimbursement changes under the Physician Fee Schedule (PFS), ranging in topic from new reimbursement codes to recalibrated weights for procedures to expanded Medicare service coverage from policy changes in the Medicare Shared Savings Program to telehealth flexibilities. Below are some of the more material ones to physician providers overall.

Estimated total Medicare spending for physicians. CMS projects aggregate Medicare spending to physicians will fall 2.93%, or $1.8B, due to the year-end expiration of two statutory payment add-ons (1.2% for CY24 and 1.68% for the period between March 8 and December 31 of this year). Recall Congress had enacted these and other increases to mitigate the fallout from sizable budget neutrality cuts triggered by the evaluation and management coding system overhaul nearly 5 years ago. Notably, absent the expiring statutory add-ons, the other CY25 final Medicare physician policies – new codes, recalibrated procedural weights, phased-in clinical labor inputs – barely impact total spending.

Medicare spending projections by medical specialty. Excluding the 2.93% statutory add-on, CMS anticipates that aggregate Medicare spending by medical specialty will range between -2% and +2%. It projects a flat change in total PFS spending for physical therapy (**USPH**), emergency medicine (**Envision, TeamHealth, US Acute Care**), dermatology, and gastroenterology, while total Medicare PFS spending for radiology (**RDNT, Radiology Partners**) in physician offices and freestanding centers is estimated to fall 1% but rise 1% when provided in a hospital.

Physician conversion factors. CMS calculates a CY25 conversion factor of $32.3465, which is down 2.8% from CY24's $33.2875. This decline reflects the expiration of the above legislative add-ons, a lacking inflationary update for CY25 and a positive adjustment of 0.02% related to recalibrating the procedural weights.

General supervision of physical therapy assistants. CMS is loosening its requirement for direct supervision of physical and occupational therapy assistants by a licensed therapist when in the private practice setting. Instead, it decided to permit general supervision. This change is intended to give more leeway to who and where the therapy is being provided but the

underlying payment policy where therapy provided by assistants remains at 85% of the amount therapists would receive for the same service.

New procedural codes and coverage. CMS is creating three new codes for advanced primary care management services, three new codes for digital mental health treatment devices, and new codes for atherosclerotic cardiovascular disease risk assessment/management services and codes for patients in crises, including those with suicidal ideation. Additionally, it is expanding its coverage for certain dental care when treatment would affect the outcome of other medical services. Specifically, it will reimburse for any dental or oral exams in the inpatient/outpatient settings prior to dialysis or any services for treating a dental infection prior to dialysis. The agency is considering if it should expand this coverage policy to other chronic illnesses like diabetes or hemophilia.

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