

CY 2025 Hospital Outpatient Prospective Payment System (HOPPS), CMS-1809-P Proposed Rule Summary

On July 10, 2024, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Hospital Outpatient Prospective Payment System (HOPPS) for CY 2025. The CY 2025 proposed rule is 984 pages in length and located in its entirety at the following link: <https://www.federalregister.gov/public-inspection/2024-15087/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical>.

The format of the following information is intended to serve as a summary of the final changes and readers are encouraged to view the document in its entirety for further details.

Highlights

- CMS proposes a 2.6 percent increase to the outpatient department (OPD) fee schedule.
 - Based on the market update from the Inpatient Prospective Payment System (IPPS) of 3.0 percent and a 0.4 percent productivity adjustment decrease.
- CMS proposes a conversion factor (CF) of \$89.379 for hospitals that meet the Hospital OQR reporting requirements; and applying the 2 percent reduction to those that do not with a CF equal to \$87.636.
- CMS estimates total payments to HOPPS providers will be approximately \$88.6 billion, an increase of approximately \$5.2 billion compared to CY 2024 HOPPS payments.
- CMS proposes an increase of 2.6 percent to payment rates for ambulatory surgical centers (ASCs) that meet the quality reporting requirements under the ASCQR Program.
 - This increase is based on the extension of the hospital market percentage increase and will be continued 2025 as continued response to impacts due to the COVID-19 public health emergency (PHE). CMS anticipates spending an increase of \$202 million compared to CY 2024 payments.
- Cancer hospital payment payment-to-cost ratio (PCR) proposed at 0.87 for the 11 designated hospitals.
- CMS proposes to continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite APC payment methodology.
- CMS proposes to assign several new technologies to new APCs for CY 2025.

Within the following pages are expanded details and explanations of the key highlights pertinent to interventional radiology as outlined above.

Payment Rates

CMS proposes using the CY 2023 claims data for ratesetting for CY 2025 which follows the usual 2-year difference in data for ratesetting due to allowance for 1-year of timely filing for billing.

The Outpatient Department (OPD) increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital charges.

- CMS proposes a 2.6 percent increase to the OPD fee schedule.
 - Based on the market update from the Inpatient Prospective Payment System (IPPS) of 3.0 percent and a 0.4 percent productivity adjustment decrease.
- CMS proposes a conversion factor (CF) of \$89.379 for hospitals that meet the Hospital OQR reporting requirements; and applying the 2 percent reduction to those that do not with a CF equal to \$87.636.
- CMS estimates total payments to HOPPS providers will be approximately \$88.6 billion, an increase of approximately \$5.2 billion compared to CY 2024 HOPPS payments.
- CMS proposes an increase of 2.6 percent to payment rates for ambulatory surgical centers (ASCs) that meet the quality reporting requirements under the ASCQR Program.
 - This increase is based on the extension of the hospital market percentage increase and will be continued for 2025 as continued response to impacts due to the COVID-19 public health emergency (PHE). CMS anticipates spending an increase of \$202 million compared to CY 2024 payments.
- Cancer hospital payment payment-to-cost ratio (PCR) proposed at 0.88 for the 11 designated hospitals.

Wage Index

CMS proposed to continue applying a wage index of 1.0000 for frontier state hospitals. This policy has been in place since CY 2011. This ensures the lower population states are not “penalized” in reimbursement due to the low number of people per square mile when compared to other states.

CMS proposed for FY 2025 and subsequent years to apply a 5 percent cap on any decreases to a hospital’s wage index from the previous year’s wage index. The wage index for FY 2024 would not be less than 95 percent of the finalized wage index for FY 2022 and would continue for subsequent years where the wage index for a given year would not be less than 95 percent of final wage index for the prior year. This adjustment would also apply to outpatient hospitals.

CMS also proposed to use the FY 2025 IPPS post-reclassified wage index for urban and rural areas as the wage index for HOPPS to determine the wage adjustments for both the HOPPS payment rate, and the copayment rate for CY 2025. Those hospitals that are paid under the OPDS, but not under the IPPS, do not have an assigned hospital wage index under the IPPS. Therefore, non-IPPS hospitals paid under the OPDS are assigned a wage index as if they were paid under IPPS based on geographic location, any applicable wage index policies and adjustments. CMS proposed to continue this policy for CY 2025.

Standardizing Ambulatory Payment Classifications (APCs) Payment Weights

Ambulatory payment classifications (APCs) group services which are considered clinically comparable to each other with respect to the resources utilized and the associated costs. For CY 2025, CMS proposed to continue using HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient), in APC 5012 (Level 2 Examinations and Related Services) as the standardized code for the relative payment weights. A relative payment weight of 1.00 is proposed to be assigned to APC 5012 (code G0463).

For CY 2025, CMS proposed to continue to pay code G0463 at a payment rate of 40 percent of the HOPPS rate for any outpatient off-campus hospital setting, excepted and nonexcepted. This continues to be the method for controlling the overutilization of this code in the outpatient setting.

CMS finalized in CY 2023 to exempt excepted off-campus provider-based departments (PBDs) (departments that bill the modifier “PO” on claim lines) of rural Sole Community Hospitals (SCHs) and designated as rural for Medicare payment purposes. CMS recognizes the use of the clinic visit in some settings is supported even if it means the rate is higher than in other settings. This is due to concerns for beneficiaries and access to quality care. Therefore, to ensure access is possible, several special payment provisions for rural providers exist, and the exemption of the clinic visit payment policy is one of them. Rather than payment at 40 percent of the HOPPS rate, the clinic visit payment policy which applies a Physician Fee Schedule-equivalent payment rate for the clinic visit service would be paid at 100 percent of the HOPPS rate.

For CY 2025, CMS is proposing to continue this policy of exempting excepted off-campus PBDs of rural SCHs from the clinic visit policy.

Multiple Imaging Composite APC

CMS finalized, without modification, their proposal to continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite APC payment methodology. It has been finalized to utilize the costs derived from CY 2023 claims data to set the CY 2025 proposed payment rates, except where otherwise indicated. Standard APC assignments will continue to apply for single imaging procedures and multiple imaging procedures performed across imaging families. A single imaging session performed “with contrast” is part of a composite APC when at least one or more imaging procedures from the same family are also performed with contrast on the same date of service. For example, if a hospital performs one MRI without contrast during the same session as one with contrast, the payment rate will be for the “with contrast” composite APC.

The five multiple imaging composite APCs established in CY 2009 are:

- APC 8004 (Ultrasound Composite);
- APC 8005 (CT and CTA without Contrast Composite);
- APC 8006 (CT and CTA with Contrast Composite);
- APC 8007 (MRI and MRA without Contrast Composite); and
- APC 8008 (MRI and MRA with Contrast Composite).

Table 3 within the CY 2025 HOPPS proposed rule contains the imaging families and multiple imaging procedures for the composite APCs.

Exclusion of Non-Opioid Products for Pain Relief from Packaging

The Consolidated Appropriations Act, 2023 addressed the need for CMS to provide additional payments for non-opioid treatments for pain relief on or after January 1, 2025, and before January 1, 2028. The Secretary of Health and Human Services cannot package payment for non-opioid treatment for pain relief with other covered outpatient hospital department services. Instead, a separate payment must be made for the non-opioid treatment for pain relief.

Supervision of Diagnostic Services

Supervision requirements for diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests paid under the HOPPS are outlined at the code level in the MPFS files provided by CMS. Revisions were made to during the public health emergency to ensure an adequate number of health care professionals were available to support critical COVID-19-related and other diagnostic testing needs and provide needed medical care during the PHE as outlined in the President’s Executive Order 13890 on “Protecting and Improving Medicare for Our Nation’s Seniors”.

For 2025, CMS is proposing to extend the definition of direct supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) services and diagnostic services via audio-video real-time communications technology (excluding audio-only) through December 31, 2025. This proposal aligns with other Medicare proposals related to physician supervision under the Medicare Physician Fee Schedule (MPFS) through 2025.

Proposed Payment for Diagnostic Radiopharmaceuticals

Historically diagnostic radiopharmaceuticals have been packaged into the imaging they are preformed with and not paid separately. CMS has done this for multiple reasons, the primary being they believe packaging policies are an inherent principal of HOPPS. However, they also feel strongly about ensuring availability of new and innovative diagnostic services for beneficiaries.

For the CY 2024 proposed rule CMS sought comments from stakeholders regarding payment for diagnostic radiopharmaceuticals. They were looking for input whether to exclude diagnostic radiopharmaceuticals from the list of items which are not paid separately when their estimated day cost is greater than the threshold as applies to other non-pass through drugs and biologicals. Specifically, CMS sought comments on the following 5 action items:

1. Paying separately for diagnostic radiopharmaceuticals with per-day costs above the OPPS drug packaging threshold of \$140;
2. Establishing a specific per-day cost threshold that may be greater or less than the OPPS drug packaging threshold;
3. Restructuring APCs, including by adding nuclear medicine APCs for services that utilize high-cost diagnostic radiopharmaceuticals;
4. Creating specific payment policies for diagnostic radiopharmaceuticals used in clinical trials; and
5. Adopting codes that incorporate the disease state being diagnosed or a diagnostic indication of a particular class of diagnostic radiopharmaceuticals.

CMS indicated they have always believed diagnostic radiopharmaceuticals were intended to be used in nuclear medicine procedures as supplies for diagnostic procedures, therefore, packaged into the primary service. The continued growing expense of diagnostic radiopharmaceuticals continues to put limitations for many hospitals especially when there is no payment comparable to the expense.

For 2025, CMS is proposing to pay separately for any diagnostic radiopharmaceutical with a per day cost greater than \$630. Any diagnostic radiopharmaceutical with a per day cost <\$630 would continue to be packaged under the current policy.

CMS is soliciting comments from stakeholders whether the threshold of \$140, proposed for CY 2025 for drugs and biologicals, is recommended. Because diagnostic radiopharmaceuticals act as supplies and are ancillary to a primary procedure, unlike many drugs and biologicals where they are the primary procedure, CMS believes

the standard packaging threshold is not appropriate and the alternative they have proposed of \$630 is the better option.

CMS has indicated within the addendum payment files they identify the diagnostic radiopharmaceuticals which exceed the proposed threshold of \$630 with status indicator “K” for easy identification. Below is Table 5 from the proposed rule which lists the qualifying diagnostic radiopharmaceuticals.

TABLE 5: Proposed Qualifying Diagnostic Radiopharmaceuticals with Per Day Costs Exceeding \$630

HCPCS Code	Short Descriptor	Proposed CY 2025 Status Indicator Assignment
A9515	Choline c-11	K
A9521	Tc99m exametazime	K
A9542	In111 ibritumomab, dx	K
A9547	In111 oxyquinoline	K
A9548	In111 pentetate	K
A9557	Tc99m bicipate	K
A9568	Technetium tc99m arcitumomab	K
A9569	Technetium tc-99m auto wbc	K
A9570	Indium in-111 auto wbc	K
A9572	Indium in-111 pentetreotide	K
A9582	Iodine i-123 iobenguane	K
A9584	Iodine i-123 ioflupane	K
A9586	Florbetapir f18	K
A9587	Gallium ga-68	K
A9588	Fluciclovine f-18	K
A9591	Fluoroestradiol f 18	K
A9592	Copper cu 64 dotatate diag	K
A9593	Gallium ga-68 psma-11 ucsf	K
A9594	Gallium ga-68 psma-11, ucla	K
A9595	Piflu f-18, dia 1 millicurie	K
A9596	Gallium illuccix 1 millicurie	K*
A9602	Fluorodopa f-18 diag per mci	K**
A9800	Gallium locametz 1 millicuri	K***
C9067	Gallium ga-68 dotatoc	K
Q9982	Flutemetamol f18 diagnostic	K
Q9983	Florbetaben f18 diagnostic	K

*HCPCS code A9596 will be assigned to status indicator “G” until its pass through expiration on 06/30/2025. For the remainder of CY 2025, we would propose to assign it to status indicator “K.”

**HCPCS code A9602 will be assigned to status indicator “G” until its pass through expiration on 09/30/2025. For the remainder of CY 2025, we would propose to assign it to status indicator “K.”

***HCPCS code A9800 will be assigned to status indicator “G” until its pass through expiration on 09/30/2025. For the remainder of CY 2025, we would propose to assign it to status indicator “K.”

Submitting Comments

Comments to CMS regarding the HOPPS proposed rule **CMS-1809-P** will be submitted by SIR to CMS and are due no later than **5 pm EST September 9, 2024**.