CMS Issues 2025 Hospital Outpatient and ASC Fee Schedule



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The Centers for Medicare & Medicaid Services (CMS) recently published the calendar year 2025 Hospital Outpatient Prospective Payment System and Ambulatory Surgery Center (ASC) Payment System final rule. Under the new rule, CMS will increase payment rates by 2.9% for ASCs and for hospitals that meet certain quality reporting requirements. According to CMS, the final rule includes policies that align with several key goals of the Biden Administration, including responding to the maternal health crisis, addressing health disparities, expanding access to behavioral health care, improving transparency in the health system and promoting patient-centered care. In addition, the final rule advances CMS's commitment to strengthening Medicare, and applies lessons learned from the COVID-19 pandemic to inform the approach to quality measurement, focusing on changes that help address health inequities.

In addition to updating reimbursement rates, the final rule requires hospitals to meet new quality standards for obstetrical care, including new staffing and training requirements, standards to ensure that basic obstetrics equipment is readily available, and requirements related to the hospital's readiness to provide emergency services. CMS has also finalized rules for implementing certain provisions of the Consolidated Appropriations Act of 2023 that provide temporary additional payments for certain non-opioid treatments for pain relief in the hospital outpatient department and ASC settings through December 31, 2027. The final rule also provides updates to Medicare payment rates for intensive outpatient program services and partial hospitalization program services furnished in hospital outpatient departments and Community Mental Health Centers.

In the final rule, CMS has also introduced additional requirements under the ASC, Hospital Inpatient, Hospital Outpatient and Rural Emergency Hospital quality reporting programs, including updates to the categories of metrics that facilities must report, such as metrics related to social drivers of health and to the facility's commitment to health equity. According to the final rule, a

facility's failure to meet quality program reporting requirements may result in a reduction to reimbursements by up to 2%, depending on the scope of the failure.

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