CY 2025 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1809-P)

On July 10, 2024, the Centers for Medicare & Medicaid Services (CMS) proposed Medicare payment rates for hospital outpatient and Ambulatory Surgical Center (ASC) services. The Calendar Year (CY) 2025 Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System Proposed Rule is published annually and will have a 60-day comment period, which will end on September 8, 2024 The final rule will be issued in early November.

In addition to proposing payment rates, this year's rule includes proposed policies that align with several key goals of the Administration, including addressing health disparities, expanding access to behavioral health care, improving transparency in the health system, and promoting safe, effective, and patient-centered care. The proposed rule advances the Agency's commitment to strengthening Medicare and uses the lessons learned from the COVID-19 PHE to inform the approach to quality measurement, focusing on changes that would help address health inequities.

These proposed payment policies would affect approximately 3,500 hospitals and approximately 6,100 ASCs. As with other rules, CMS is publishing this proposed rule to meet the legal requirements to update Medicare payment policies for OPPS hospitals and ASCs annually. This fact sheet discusses the major provisions of the proposed rule (CMS-1809-P), which can be downloaded at: https://www.federalregister.gov/documents/current.

Proposed Obstetrical Services Conditions of Participation

The United States is currently facing a maternal health crisis, which has not only led to a maternal mortality rate that is among the highest in high-income countries but also disproportionately affects racial and ethnic minorities. Native Hawaiian and Pacific Islander women, Black women, and American Indian/Alaska Native (AI/AN) women are two to three times more likely to suffer a pregnancy-related death than non-Hispanic White women. Moreover, over 80% of pregnancy-related deaths are preventable. CMS has broad statutory authority to establish health and safety regulations, which includes the authority to establish requirements that protect the health and safety of pregnant, postpartum, and birthing women. However, there are currently no baseline requirements for maternal health regarding organization, staffing, training, maternal health-focused quality assessment and performance improvement (QAPI), and delivery of obstetrical (OB) services in hospitals and Critical Access Hospitals (CAHs). CMS believes that proposing revisions to the current Conditions of Participation for OB services ensures that all Medicare and Medicaid participating hospitals and CAHs offering these services are held to a consistent standard of high-quality maternity care that protects the health and safety of patients.

Specifically, CMS is proposing new Conditions of Participation (CoPs) for hospitals and CAHs for obstetrical services, including new requirements for maternal quality assessment and performance improvement (QAPI), baseline standards for the organization, staffing, and delivery of care within obstetrical units, and staff training on evidence-based maternal health practices on

an annual basis. CMS is further proposing revisions to the emergency services CoP related to emergency readiness for hospitals and CAHs that provide emergency services. Lastly, CMS is proposing revisions to the Discharge Planning CoP for all hospitals and CAHs related to transfer protocols. These proposals were informed by available evidence, stakeholder input, and requests for information in the FY 2023 IPPS/LTCH PPS and FY 2025 IPPS proposed rules. Lastly, CMS is soliciting comments on whether these proposed requirements should also apply to rural emergency hospitals (REHs).

Proposed Provisions for OB Services CoP

Organization and Staffing

CMS is proposing a new standard that requires that for hospitals and CAHs providing OB services outside of an emergency department, such services must 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. This proposed requirement mirrors other hospital and CAH optional services CoPs (such as surgical services) and is foundational to ensuring high-quality, safe care. Additionally, we are proposing that the organization of the OB services be appropriate to the scope of services offered by the facility and be integrated with other departments in the facility. For example, in order to provide high-quality and safe care, a labor and delivery unit must ensure good communication and collaboration with services such as laboratory, surgical, and anesthesia services when applicable. CMS is also proposing that OB patient care units be supervised by an individual with necessary education and training, such as an experienced registered nurse (RN), certified midwife, nurse practitioner, physician assistant, or doctor of medicine or osteopathy. Lastly, CMS is proposing that OB privileges be delineated for all practitioners providing OB care, and a roster of practitioners specifying the privileges of each practitioner must be maintained. This process is important to ensure that practitioners have the necessary education, training, and experience to provide safe, effective care and to safely perform specific procedures.

Delivery of service

CMS is proposing a new standard that requires OB services to be consistent with the needs and resources of the facility. Additionally, the policies governing OB care must assure high standards of medical practice and patient care and safety. CMS believes that a basic set of equipment should be in place in hospitals and CAHs providing OB services to ensure efficient, effective delivery of care as well as a timely response to emergency situations. Therefore, we are proposing that labor and delivery rooms have certain basic resuscitation equipment readily available, including a call-in system, cardiac monitor, and fetal doppler or monitor. Lastly, CMS is proposing that the facility ensure that it has adequate, readily available provisions and protocols consistent with nationally recognized and evidence-based guidelines for OB emergencies, complications, immediate post-delivery care, and other patient health and safety events. Although we are not requiring specific items, examples of provisions would include equipment, supplies, and blood used in treating emergency cases.

Staff Training

CMS is proposing a new standard that requires hospitals and CAHs that offer OB services outside of the emergency department to develop policies and procedures to ensure that relevant staff are trained on certain topics aimed at improving the delivery of maternal care. CMS proposes that these training topics reflect the scope and complexity of services offered, including, but not limited to, facility-identified evidence-based best practices and protocols to improve the delivery of maternal care within the facility. Additionally, CMS is proposing that hospitals and CAHs use findings from their QAPI programs to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis. Lastly, we are proposing that the hospitals and CAHs providing OB services identify which staff must complete the trainings, document in staff personnel records that training was successfully completed, and be able to demonstrate staff knowledge on the training topics identified.

Quality Assessment and Performance Improvement (QAPI) Program

CMS is proposing to revise the existing QAPI CoP for hospitals and CAHs that offer OB services to promote safe and high-quality care for all pregnant, birthing, and postpartum patients. We are proposing that a hospital or CAH with OB services be required to use its QAPI program to assess and improve health outcomes and disparities among OB patients on an ongoing basis. Specifically, at a minimum, the facility would 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.

Additionally, we are proposing to require that each OB facility's leadership be involved in the facility's QAPI activities. Lastly, per existing state statutes as applicable, facilities are already required to report data to maternal mortality review committee/s (MMRC/s). Therefore, CMS is proposing that if a MMRC is available at the state or local jurisdiction in which the facility is located, hospitals and CAHs that offer OB services must have a process for incorporating information and data from the MMRC into the hospital QAPI program.

Emergency Services Readiness

Medicare-participating hospitals and CAHs with emergency departments must be continually prepared to provide appropriate medical screenings and offer stabilizing treatment to a patient in the emergency department with an emergency condition or when needed, transfer such patients

to receive stabilizing care that the originating hospital cannot provide. Such readiness is essential to the health and safety of emergency services patients and relies on adequate staff training, provisions, protocols, and supplies.

Therefore, CMS is proposing a revised Emergency Services CoP to improve facility readiness in caring for emergency services patients, including pregnant, birthing, and postpartum women. It is important to note that these proposed emergency services requirements would apply to all hospitals and CAHs offering emergency services, regardless of whether they provide specialty services, such as OB services. CMS is proposing that hospitals and CAHs with emergency services be required to have adequate provisions and protocols to meet the emergency needs of patients. Hospitals and CAHs must have protocols consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions. Additionally, for hospitals and CAHs with emergency services, we are proposing that applicable staff would need to be trained on these protocols and provisions annually, and documentation would be expected to show those staff have successfully completed such facility-identified training and knowledge on these topics.

Lastly, CMS is proposing, for hospitals only, that provisions include equipment, supplies, and medication used in treating emergency cases. Although we are not requiring specific items, the available provisions must include:

(1) drugs, blood and blood products, and biologicals commonly used in lifesaving procedures;
(2) equipment and supplies commonly used in lifesaving procedures;
(3) a call-in system for each patient in each emergency services treatment area.

Transfer Protocols

CMS is proposing to require hospitals to have written policies and procedures for transferring patients under its care, which would be inclusive of hospital inpatients (e.g., transfer from one unit to another in the same hospital) to the appropriate level of care as needed to meet the patients' needs. This would also include transferring the patient to another hospital if deemed necessary. Lastly, we are proposing that hospitals provide training to the relevant staff regarding the hospital policies and procedures for transferring patients under its care.

<u>Medicaid and CHIP Continuous Eligibility</u>

Section 5112 of the Consolidated Appropriations Act, 2023 (CAA, 2023) amended section 1902(e)(12) of the Act and added a new paragraph (K) to section 2107(e)(1) of the Act to make the previously optional continuous eligibility policy a requirement under the state plan or a waiver of the state plan for children enrolled in Medicaid and CHIP. In this proposed rule, CMS proposes updates to the Medicaid and CHIP regulations to codify the requirements of the CAA, 2023. Specifically, CMS proposes to require 12-months of continuous eligibility for children under the age of 19 enrolled in Medicaid and CHIP. CMS proposes to remove the previous options of applying continuous eligibility to a subgroup of enrollees or limiting continuing

eligibility to a time period of less than 12 months. For CHIP, CMS also proposes to remove failure to pay premiums as an optional exception to continuous eligibility.

Medicaid Clinic Services Four Walls Exceptions

CMS is proposing to amend the Medicaid clinic services regulation to authorize federal reimbursement for services furnished outside the "four walls" of a freestanding clinic by IHS/Tribal clinics. In addition, at state option, federal reimbursement would also be available for services provided by behavioral health clinics and services provided by clinics located in rural areas. For clinics located in rural areas, CMS is not proposing a specific definition of rural but is seeking public comment on different alternative definitions for consideration in final rulemaking.