Kansas Hospital Association

Summary of the Calendar Year 2025 Outpatient Prospective Payment System Final Rule

The Centers for Medicare and Medicaid Services released the CY 2025 Outpatient Prospective Payment System (OPPS) Final Rule on November 1, 2024. KHA has prepared the summary of major provisions below. Our comments to CMS on the proposed rule can be found here.

Summary of Major Provisions:

- OPPS payment increase of 2.9%.
  - Payment adjustment of 7.1% for sole community hospitals (SCHs)

- Intensive Outpatient Program & Partial Hospitalization Program
  - CMS is maintaining the existing rate structure for intensive outpatient program (IOP) services furnished in HOPDs and Community Mental Health Centers (CMHCs).

- Changes to the Inpatient Only (IPO) List
  - Adding three liver allograft services for which does were newly created.
  - Removed a pelvis fixation code (CPT code 22848).

- Access to Non-Opioid Treatments for Pain Relief
  - Providing a temporary separate payment for certain non-opioid treatments for pain relief in the hospital outpatient department (HOPD) and ASC settings from January 1, 2025, through December 31, 2027.

- Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) Services and Diagnostic Services Furnished to Hospital Outpatients
  - CMS is continuing to allow for the direct supervision of CR, ICR, PR services and diagnostic services via audio-video real-time communications technology through December 31, 2025.

- Request for Comment on Payment Adjustments under the IPPS and OPPS for Domestic Personal Protective Equipment
  - CMS will pursue rulemaking in 2026 to propose a new payment methodology for domestic personal protective equipment and expand the payment adjustments to domestic non-surgical N95 respirators and domestic nitrile gloves.

- Payment for HIB Pre-Exposure Prophylaxis (PrEP) in HOPDs
  - CMS will cover HIV PrEP drugs as an additional preventive service and related services.

- Improving Payment for High-Cost Diagnostic Radiopharmaceuticals
  - CMS will pay separately for diagnostic radiopharmaceuticals with per day costs above a threshold of $630 and updating the $630 threshold in CY 2026 and subsequent years by the

Producer Price Index (PPI) for Pharmaceutical Preparations. Qualifying products will be paid separately at their mean unit cost.

- Exclusion of Cell and Gene Therapies from Comprehensive Ambulatory Payment Classification (C-APC) Packaging
    - CMS will exclude qualifying cell and gene therapies from C-APC packaging when those cell and gene therapies are not functioning as integral, ancillary, supportive, dependent, or adjunctive to the primary C-APC service.

- Add-on Payment for Domestically Produced Technetium-99m (Tc-99m)
    - CMS is adopting an add-on payment applicable to radiopharmaceuticals that use Tc-99m produced without use of highly enriched uranium for CY 2025
    - For CY 2026, CMS will replace the add-on payment with a new add-on payment of $10 per dose for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99.

- Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process
    - CMS is reducing the timeframe for prior authorization requests for OPD services from 10-business days to 7-calendar days for standard reviews.

- Quality:
    - Health Equity Measures for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs
        - CMS finalized adoption of the:
            - Hospital Commitment to Health Equity measure in the OQR and REHQR Programs
            - Facility Commitment to Health Equity measure in the ASCQR Program
            - Screening for Social Drivers of Health (SDOH) measure in all three programs beginning with voluntary reporting for the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period.
            - Screen Positive Rate for SDOH measure in all three programs beginning with voluntary reporting for the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period.
    - Hospital Outpatient Quality Reporting (OQR) Program
        - CMS finalized adoption of the:
            - 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) beginning with voluntary reporting for the CY 2026 reporting period followed by mandatory reporting beginning with the CY 2027 reporting period.

        - CMS removed the following measures:
            - MRI Lumbar Spine for Low Back Pain measure beginning with the CY 2025 reporting period.
            - Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery measure beginning with the CY 2025 reporting period.
        - CMS will require that electronic health record technology be certified to all electronic clinical quality measures (eCQMs) available to reporting beginning with the CY 2025 reporting period.
        - CMS will publicly report the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients Measure – Psychiatric/Mental Health Patients stratification on Care Compare beginning with CY 2025.
    - Rural Emergency Hospital Quality Reporting (REHQR) Program
        - CMS finalized extension of the reporting period for the Risk-Standardized Hospital Visited Within 7 Days After Hospital Outpatient Surgery measure from 1 year to 2 years beginning with the CY 2027 program determination.
        - CMS clarified when, after status conversion, REHs are required to report data under the REHQR Program to be the first day of the quarter following the date that a hospital has been designated as converted to an REH.
    - Hospital Inpatient Quality Reporting Program
        - CMS finalized the voluntary reporting of the core clinical data elements (CCDEs) and linking variables for both the Hybrid Hospital-Wide Readmission (HWR) and Hybrid Hospital-Wide Standardized Mortality (HWM) measures for the performance period of July 1, 2024, through June 30, 2024, impacting the FY 2026 payment determination.
        - CMS extended the voluntary reporting of CCDEs and linking variables for an additional year for the performance period of July 1, 2024, through June 30, 2025, impacting the FY 2027 payment determination.
    - Overall Hospital Quality Star Rating
        - CMS summarized comments on the RFI issued on potential modifications to the Safety of Care measure group in the Overall Hospital Quality Star Rating methodology that would adjust the potential for hospitals performing in the bottom 25% in the Safety of Care measure group to be eligible to receive the highest 5-star rating.
        - Future rulemaking could be expected on this topic.

- Individuals Formerly in the Custody of Penal Authorities
    - CMS is narrowing the definition of "custody" in Medicare's payment exclusion rule and revising the Medicare special enrollment period for formerly incarcerated individuals.
        - CMS will now pay for items and services for individuals who are on bail, parole, probation, and home detention or those who reside in halfway houses.
        - CMS will enable the special enrollment period to be used by formerly incarcerated individuals who have been released from incarceration or on bail, parole, probation, or home detention or who are residents in halfway houses.

- Continuous Eligibility in Medicaid and CHIP
    - CMS codifies the requirement within the CAA, 2023 for states to provide 12 months of continuous eligibility to children under the age of 19 in Medicaid and CHIP, with limited exceptions.
    - Children can no longer be disenrolled from CHIP during a continuous eligibility period for failure to pay premiums.

- Medicaid Clinic Services Four Walls Exceptions:
    - CMS is adding three new exceptions to the Medicaid clinic services benefit four walls requirements.
        - Clinics will now be able to offer services outside the four walls of the clinic if a clinic is an IHS/Tribal clinic, a behavioral health clinic, or a clinic located in a rural area.

- Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals
    - CMS finalized a new Conditions of Participation (CoP) for hospitals and CAHs for obstetrical services, including new requirements for maternal quality assessment and performance improvement (QAPI), as well as baseline standards for the organization, staffing, and delivery of care within obstetrical units, and staff training on evidence-based best practices every 2 years.
    - CMS revised the emergency services CoP related to emergency readiness for hospitals and CAHs that provide emergency services.
    - CMS revised the Discharge Planning CoP for all hospitals related to transfer protocols.
    - CMS will phase in the implementation of these requirements to provide hospitals and CAHs additional time to come into compliance.

- OB Health and Safety Standards: Organization and Staffing (Effective January 1, 2026)
    - OB services in hospitals and CAHs must be well organized and provided in accordance with nationally recognized acceptable standards of practice for the health care of pregnant, birthing, and postpartum patients.
    - The organization of the OB services must be appropriate to the scope of services offered by the facility and be integrated with other departments in the facility.
    - OB patient care units must be supervised by an individual with the necessary education and training, such as an experienced RN, certified midwife, NP, PA, or physician.
    - OB privileges must be granted subject to written criteria for all practitioners providing OB care in accordance with the current requirements for hospitals and CAHs.

- OB Health and Safety Standards: Delivery of Service (Effective January 1, 2026)
    - Hospitals and CAHs will now be required to keep basic equipment for treating OB cases at the facility and be readily available for treating OB cases in order to meet the needs of patients in accordance with the scope, volume, and complexity of services offered by the facility.

        - This equipment includes a call-in system, cardiac monitor, and fetal doppler/monitor.
        - It is up to hospitals to determine how to stock equipment in a manner that aligns with the facility's scope, volume, and complexity of OB services offered (that is, per facility, per unit, or per room).
    - Hospitals must ensure they have 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.
        - Specific items are not required, but examples of provisions include equipment, supplies, and blood used in treating emergency cases.

- OB Health and Safety Standards: Training for OB Staff in Hospitals and CAHs (Effective January 1, 2027)
    - Hospitals and CAHs must develop policies and procedures to ensure that relevant staff are trained on certain topics aimed at improving the delivery of maternal care.
        - CMS requires 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.
    - Hospitals and CAHs must use findings from their QAPI programs to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis.
    - The governing body of the hospital must identify and document which staff must complete initial training and subsequent biannual training. Hospitals and CAHs must also document in staff personnel records that training was successfully completed and be able to demonstrate staff knowledge on the training topics identified.

- OB Health and Safety Standards: Quality Assessment and Performance Improvement (QAPI) Program (Effective January 1, 2027)
    - Hospitals and 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, facilities at a minimum must:
        - Analyze data and quality indicators collected for the QAPI program by diverse subpopulations as identified by the facility among OB patients.
        - 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.
        - 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.
        - Conduct at least one performance improvement project focused on improving health outcomes and disparities among the hospital's population(s) of obstetrical patients annually.

- OB leadership must engage in OB QAPI activities.
- Hospitals and CAHs that offer OB services must have a process for incorporating publicly available information and data from Kansas' Maternal Mortality Review Committee into the hospital or CAH QAPI program.

- Emergency Services Readiness (Effective July 1, 2025)
  - CMS issued revisions to the Emergency Services' CoP applicable to all hospitals and CAHs that offer emergency services.
    - Hospitals and CAHs must have adequate provisions and protocols to meet the emergency needs of patients.
    - Specifically:
      - Must have protocols consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions.
      - Staff must be trained on these protocols and provisions annually, and documentation must show that staff has successfully completed such training and can demonstrate knowledge on these topics.
    - For hospitals only (not CAHs), CMS is also requiring that facilities set aside provisions for emergencies, including equipment, supplies, and medications used in treating emergency cases. CMS does not require specific items, but available provisions must include:
      - Drugs, blood and blood products, and biologicals commonly used in lifesaving procedures.
      - Equipment and supplies commonly used in lifesaving procedures.
      - Call-in system for each patient in each emergency services' treatment area.

- Transfer Protocols (Effective July 1, 2025)
  - Hospitals must have written policies and procedures for transferring patients under its care (including intra-hospital transfers of hospital inpatients) to the appropriate level of care as needed to meet the patient's needs.
  - Hospitals must provide annual training to the relevant staff regarding the hospital policies and procedures for transferring patients under its care (this requirement is not applicable to CAHs and REHs)

- Phased In Implementation
  - Implementation will be phased in for hospitals and CAHs in 3 phases over a 2-year period.
    - Phase 1 would require facilities to comply with the following requirements 6 months following the effective date of the final rule:
      - Emergency services readiness for hospitals and CAHs
      - Transfer protocols for hospitals only.
    - Phase 2 would require facilities to comply with the following requirements 1 year following the effective date of the final rule.

- Organization, staffing, and delivery of services for hospitals and CAHs

- Phase 3 would require facilities to comply with the following requirements 2 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