Illinois Health and Hospital Association

RULE SUMMARY

NOVEMBER 2024

MEDICARE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Overview and Resources

On Nov. 1, 2024, the Centers for Medicare and Medicaid Services (CMS) released its final calendar year (CY) 2025 payment rule for the Medicare Outpatient Prospective Payment System (OPPS). The final rule includes updates to the Medicare fee-for-service (FFS) OPPS payment rates based on changes set forth by CMS and those previously adopted by the US Congress. In addition to the regular updates to wage indexes and market basket, the following policies are being adopted in this rule:

- Adding three services to the Inpatient-Only (IPO) list;
- Updating area wage indexes using county and Core-Based Statistical Area (CBSA) delineations based on Office of Management and Budget (OMB) Bulletin No. 23-01;
- Adding two new status indicators representing separately payable, non-opioid post-surgical pain management products;
- Changes to the Obstetrical Services Conditions of Participation (CoP);
- Updating requirements for the Hospital Outpatient Quality Reporting (OQR) Program;
- Updating requirements for the Rural Emergency Hospital Quality Reporting (REHQR) Program; and
- Updating payment rates and policies for Ambulatory Surgical Centers (ASCs).

Program changes will be effective for discharges on or after Jan. 1, 2025, unless otherwise noted. CMS estimates a $4.7 billion increase in OPPS payments for CY 2025 over CY 2024. The final rule and other resources related to the OPPS are available on the CMS website. Comments are due to CMS by Dec. 31, 2024 and can be submitted electronically at http://www.regulations.gov by using the website's search feature for "CMS-1809-FC".

OPPS Payment Rates

CMS typically uses the most up-to-date claims data and cost report data (cost report data is one year behind claims data) to set OPPS rates for the upcoming year. CMS is adopting the use of CY 2023 claims data and CY 2022 Healthcare Cost Report Information System (HCRIS) data for CY 2025 OPPS rate setting.

The table below shows the final CY 2024 conversion factor compared to the final CY 2025 conversion factor:

	Final CY 2024	**Final CY 2025**	**Percent Change**
OPPS Conversion Factor	$87.382	$89.169	+2.05%

Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACH)

CMS will continue the 7.1% budget neutral payment increase for rural SCHs and EACHs. This payment add-on excludes separately-payable drugs, biologicals, brachytherapy sources, devices paid under the pass-through payment policy, and items paid at charges reduced to costs. CMS will maintain this for future years until data supports a change to the adjustment.

Outlier Payments

To maintain total outlier payments at 1% of total OPPS payments, CMS used CY 2023 claims to calculate a finalized CY 2025 outlier fixed-dollar threshold of $8,000 (as proposed). This is a 3.2% increase compared to the current threshold of $7,750. Outlier payments will continue to be paid at 50% of the amount by which the hospital's cost exceeds 1.75 times the Ambulatory Payment Classification (APC) payment amount when both the 1.75 multiplier threshold and the fixed-dollar threshold are met.

Wage Index and Labor-Related Share

As in past years, for CY 2025 OPPS payments, CMS will continue to use the federal fiscal year (FFY) 2025 Inpatient PPS (IPPS) wage indexes, including all reclassifications, add-ons, rural floors, and budget neutrality adjustments.

CMS applies a 5% cap on any hospital wage index decrease compared with the previous year's wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner nationally. This also means that if a hospital's prior CY wage index is calculated with the application of the 5% cap, the following year's wage index will not be less than 95% of the hospital's capped wage index in the prior year. Lastly, a new hospital will be paid the wage index for the area in which it is geographically located for its first full or partial year with no cap applied, because a new hospital will not have had a wage index in the prior year. CMS is adopting a budget neutrality factor of 0.9995 for the impact of the 5% cap on wage index decreases.

CMS is finalizing a wage index and labor-related share budget neutrality factor of 0.9927 for CY 2025 to ensure that aggregate payments made under the OPPS are not greater or less than what will otherwise be made if wage index adjustments had not changed.

The wage index is applied to the portion of the OPPS conversion factor that CMS considers to be labor-related. For CY 2025, CMS will continue to use a labor-related share of 60%.

Low Wage Index Hospitals

In order to address wage index disparities between high- and low-wage index hospitals, CMS had made a variety of changes that will affect the wage index and wage index-related policies in the FFY 2020 IPPS final rule. As adopted, this policy was to be in effect for a minimum of four years (through FFY 2024) in order to be properly reflected in the Medicare cost report for future years. CMS believes that the effects of the COVID-19 public health emergency (PHE) has complicated their ability to evaluate how successful this low wage index hospital policy was for increasing employee compensation.

This policy is subject to litigation in *Bridgeport Hospital, et al., v. Becerra,* in which the court found that the Secretary did not have the authority to adopt this low wage index policy and has ordered that the policy be vacated. In the FFY 2025 IPPS Interim Final Action with Comment Period, CMS removed the low wage index policy from the IPPS setting. However, CMS believes that their statutory authority in the OPPS setting differs enough from the IPPS setting. As such, CMS will continue the policy that hospitals with a wage index value in the bottom quartile of the nation will have that wage index increased by a value equivalent to half of the difference between the hospital's pre-adjustment wage index and the 25th percentile wage index value across all hospital for CY 2025 OPPS.

CMS acknowledges the differences between the OPPS and IPPS wage index values for FFY 2025 and will explore options to realign the wage index values in future rulemaking. CMS will continue to offset these

wage index increases in a budget neutral way by incorporating a budget neutrality adjustment to the national standardized amount through the wage index budget neutrality factory.

The value of the 25th percentile wage index adopted for FFY 2025 in the FFY 2025 IPPS final rule was 0.9007. This was updated to 0.9009 in the FFY 2025 IPPS final rule correction notice but was not applied to this OPPS final rule.

Updated CBSA Delineations

On July 21, 2023, the OMB issued OMB Bulletin No. 23-01 that made a number of significant changes related CBSA delineations. To align with these changes, CMS is adopting the newest OMB delineations for the FFY 2025 IPPS wage index. See the IPPS rule summary for more information on how these changes impact hospitals.

Cost-to-Charge Ratios (CCRs)

For CY 2025, CMS will continue to use the hospital-specific overall ancillary and departmental CCRs to convert charges to estimated costs. CMS is also finalizing to not include cost report lines for non-standard cost centers in OPPS rate setting when hospitals have reported this data on cost report lines that do not correspond to the cost center number. For CY 2025, CMS will continue its policy to establish payment rates for blood and blood products using a blood–specific CCR methodology.

Comprehensive Ambulatory Payment Classification (C-APC)

CMS is not finalizing the creation of any new C-APCs for CY 2025. A list of the 72 existing C–APCs for CY 2025 can be found in Table 5.

For CY 2025 and subsequent years (proposed for CY 2025 only), CMS will exclude payment for cell and gene therapies from C-APC packaging listed in Table 3 into the payment for the primary C-APC service on the same claim when those cell and gene therapies are not functioning as integral, ancillary supportive, dependent, or adjunctive to the primary C-APC service. CMS has also finalized those products on this list with a pass-through status expiring in CY 2025 will be excluded from C-APC packaging after their pass-through status expires, which can be found in Table 130.

In accordance with the Consolidated Appropriations Act (CAA) of 2023, CMS will also exclude non-opioid treatments for pain relief that satisfy the required payment criteria from the C-APC policy. This exclusion is required by law to last from Jan. 1, 2025 through Dec. 31, 2027. Additionally, CMS is adopting the application of an 18% payment limitation per date of service billed, rather than per HCPCS dosage unit, as typically multiple dosage units of each drug or biological are billed per claim.

Composite APCs

Currently, there are six composite APCs: Mental Health Services (APC 8010) and Multiple Imaging Services (APCs 8004, 8005, 8006, 8007, and 8008). For CY 2025, CMS will continue its policy that when the aggregate payment for specified mental health services provided by a hospital to a single beneficiary on a single date of service exceeds the maximum per diem payment rate for partial hospitalization services, those services will continue to instead be paid through composite APC 8010.

In addition, CMS has finalized the payment rate for composite APC 8010 will continue to be set to that established for APC 5864 (four or more hospital-based partial hospitalization services per day) as it is the maximum partial hospitalization per diem payment rate for a hospital.

For CY 2025, CMS will continue its current composite APC payment policies for multiple imaging services from the same family and on the same date. Table 6 on pages 94–97 includes the HCPCS codes that are subject to the multiple imaging procedure composite APC policy, their respective families, and each family's geometric mean cost.

Payment for Drugs, Biologicals and Radiopharmaceuticals

CMS pays for drugs and biologicals that do not have pass-through status in one of two ways: either packaged into the APC for the associated service or assigned to their own APC and paid separately. The determination is based on the packaging threshold. CMS allows for a quarterly expiration of pass-through payment status of drugs and biologicals newly approved in order to grant a pass-through period as close to a full three years as possible, and to eliminate the variability of the pass-through payment eligibility period without exceeding the statutory three-year limit.

For CY 2025, due to comments received with the CY 2024 OPPS final rule, and to ensure that Medicaid payment policy is not disincentivizing the use of clinically-appropriate, high-cost, low-utilization diagnostic radiopharmaceuticals as well as appropriate access, CMS is finalizing a per-diem packaging threshold of $630 for diagnostic radiopharmaceuticals. Diagnostic radiopharmaceuticals with a per-day cost below this threshold will continue to be packaged as under existing policy. Following its current packaging threshold policy, beginning CY 2026, this value will be updated annually based on the producer price index (PPI) for Pharmaceuticals for Human Use (Prescription) from IHS Global, Inc (IGI).

Separately for CY 2025, CMS is finalizing a packaging threshold of $140. Drugs, biologicals, and radiopharmaceuticals (excluding diagnostic radiopharmaceuticals) that are above the $140 threshold are paid separately, using individual APCs, and those below the threshold are packaged; the baseline payment rate for CY 2025 is the average sales price (ASP)+6%. Separately payable drugs and biological products that do not have pass-through status are to be paid wholesale acquisition cost (WAC)+3%, instead of WAC+6%.

For CY 2025, CMS will continue paying for blood clotting factors and therapeutic radiopharmaceuticals with pass-through payments status at ASP+6%. If ASP data are not available, payment instead will be made at WAC+3%; or 95% of average wholesale price (AWP) if WAC data are also not available.

For CY 2025 and subsequent years, for those HCPCS codes for drugs, biologicals and therapeutic radiopharmaceuticals that are impacted by the updated drug packaging threshold, CMS is finalizing that:

- HCPCS codes for drugs, biologicals, and radiopharmaceuticals that were paid separately in CY 2024 and that are finalized for separate payment in CY 2025, and that then have per day costs equal to or less than the CY 2025 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2025 final rule, would continue to receive separate payment in CY 2025.
- HCPCS codes for drugs, biologicals, and radiopharmaceuticals that were packaged in CY 2024 and that are finalized for separate payment in CY 2025, and that then have per day costs equal to or less than the CY 2025 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2025 final rule, would remain packaged in CY 2025.
- HCPCS codes for drugs, biologicals, and radiopharmaceuticals for which we finalized packaged payment in CY 2025 but that then have per-day costs greater than the CY 2025 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the

updated ASPs and hospital claims data used for the CY 2025 final rule, would receive separate payment in CY 2025."

For CY 2025, CMS has adopted a clarification that only ASP data or MUC data (if ASP is unavailable) will be used to set payment rates under the OPPS for non-pass-through therapeutic radiopharmaceuticals that are separately payable. This results in CMS adopting the use of MUC data for said radiopharmaceuticals that are finalized as separately payable due to their cost exceeding the per-day threshold.

As there are often HCPCS codes for new drugs or biologicals that have received marketing approval, but for which there is no sales data available, the affected drugs and biologicals are assigned a non-payable indicator. However, for CY 2026, for separately payable drugs and biologicals for which CMS does not provide a payment rate, CMS has finalized that Medicare Administrative Contractors (MACs) will calculate the payment based on provider invoices (net acquisition cost, less any rebates, chargebacks, or post-sale concessions). MACs will use the invoice to determine that the drug is not policy-packaged, and that the per-day cost is above the threshold packaging amount, as applicable.

CMS states that the pass-through status will expire by Dec. 31, 2024 for 25 drugs and biologicals, listed in Table 130; by Dec. 31, 2025 for 28 drugs and biologicals listed in Table 131; and will continue/establish pass-through status in CY 2025 for 80 drugs and biologicals shown in Table 132.

Packaged Services

CMS will continue to conditionally package more ancillary services when they occur on a claim with another service, and to only pay for them separately when performed alone.

For CY 2025, CMS will continue to unpackage, and pay separately at ASP+6%, the cost of non–opioid pain management drugs that function as surgical supplies when they are furnished in the ASC setting. CMS is unpackaging these drugs to address the decreased utilization of non–opioid pain management drugs and to encourage their use rather than prescription opioids. These drugs are only eligible if the drug or biological does not have transitional pass-through payment status and the drug must not already be separately payable in the OPPS or ASC payment system.

Table 158 lists the products that are finalized to continue to have separate payment in the ASC setting under this policy for CY 2025.

Off-Campus Outpatient Departments

In CY 2019, in order to control what CMS deemed an unnecessary increase in OPPS service volume for a basic clinic visit representing a large share of the services provided at off-campus provider-based departments (PBDs), CMS expanded the Medicare Physician Fee Schedule (MPFS) payment methodology to excepted off-campus PBDs for HCPCS code G0463. As of CY 2024, this policy has the following additional exemptions:

- Excepted off-campus PBDs belonging to rural SCHs
- Application of the Community Mental Health Center (CMHC) per-diem rates for hospital partial hospitalization program (PHP) and intensive outpatient (IOP) services provided at an off-campus PBD, instead of the MPFS rate for that service; and
- Payment made for intensive cardiac rehabilitation (ICR) services.

For CY 2025, CMS will continue its policy that excepted off-campus PBDs of rural SCHs be exempt from the clinic visit payment policy as CMS believes that the volume of the clinic visit service in these hospitals is driven by factors other than the payment differential for the service. These hospitals will continue to bill HCPCS code G0463 with modifier "PO," but CMS will pay these hospitals the full OPPS payment rate.

For all other excepted off-campus PBDs, CMS will continue to pay 40% of the OPPS rate for basic clinic services in CY 2025. These excepted PBDs continue to bill HCPCS code G0463 with modifier "PO."

PHP and IOP Services

The table below compares the final CY 2024 and final CY 2025 PHP and IOP payment rates as found in Addendum A:

	Final Payment Rate 2024	Final Payment Rate 2025	% Change
APC 5851: Intensive Outpatient (3+ services) for CMHCs	$87.66	$111.24	+26.90%
APC 5852: Intensive Outpatient (4+ services) for CMHCs	$157.58	$168.32	+6.82%
APC 5853: Partial Hospitalization (3+ services) for CMHCs	$87.66	$111.24	+26.90%
APC 5854: Partial Hospitalization (4+ services) for CMHCs	$157.58	$168.32	+6.82%
APC 5861: Intensive Outpatient (3+ services) for Hospital–based IOPs	$259.40	$269.19	+3.77%
APC 5862: Intensive Outpatient (4+ services) for Hospital–based IOPs	$358.21	$408.55	+14.05%
APC 5863: Partial Hospitalization (3+ services) for Hospital–based PHPs	$259.40	$269.19	+3.77%
APC 5864: Partial Hospitalization (4+ services) for Hospital–based PHPs	$358.21	$408.55	+14.05%

CMS will continue to make outlier payments to CMHCs for 50% of the amount by which the cost for the PHP service exceeds 3.4 times the highest CMHC PHP APC payment rate implemented for that calendar year. As done in prior years, CMS will apply an 8% outlier payment cap to the CMHC's total per diem payments. CMS will also continue to include both PHP and IOP in the calculation of the CMHC outlier percentage.

Inpatient-Only (IPO) List

The IPO list specifies services/procedures that Medicare will only pay for when provided in an inpatient setting. Based on comments received, for CY 2025 CMS has finalized the removal of CPT code 22848.

For CY 2025, CMS is finalizing the addition of the following services to the IPO list and assigning them to status indicator "C":

- CPT 0894T: Cannulation of the liver allograft in preparation for connection to the normothermic perfusion device and decannulation of the liver allograft following normothermic perfusion.
- CPT 0895T: Connection of liver allograft to normothermic machine perfusion device, hemostasis control; initial 4 hours of monitoring time, including hourly physiological and laboratory assessments (e.g., perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary).

- CPT 0896T: Connection of liver allograft to normothermic machine perfusion device, hemostasis control; each additional hour, including physiological and laboratory assessments (e.g., perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment; list separately in addition to code for primary procedure).

The full list of measures that are finalized to be included on the IPO list is available in Addendum E of the final rule.

Remote Services

Due to the similarities between the new telemedicine E/M code set and the office/outpatient E/M code set, CMS believes that telemedicine E/M codes fall within the scope of the hospital outpatient clinic visit policy as the preceding codes would be reported using HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient). As the CPT codes describing these E/M visits are unrecognized by the OPPS, CMS has finalized its proposal to not recognize the telemedicine E/M code set under OPPS.

Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (FR) Services, and Diagnostic Services Furnished to Hospital Outpatients

In the April 6, 2020 "Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency" interim final rule with comment period, CMS adopted that during a PHE, for the purposes of direct supervision, a physician can be present virtually through audio/video real-time communications technology for FR, CR, and ICR services when the use of technology reduces exposure risks for the patient or the provider. The CAA of 2023 extends this policy through the end of CY 2024. In order to maintain similar policies for OPPS as PFS, CMS adopted the inclusion of FR, CR, and ICR with supervision from an NP, PA, or CNS under this policy.

In the CY 2025 PFS final rule, CMS finalized an extension of the availability of virtual direct supervision of therapeutic and diagnostic services under the PFS through Dec. 31, 2025. In order to maintain alignment between the PFS and OPPS, CMS is adopting an extension to virtual direct supervision under the OPPS through Dec. 31, 2025.

Colorectal Cancer (CRC) Screening Services

For CY 2025, CMS is adopting the following changes to CRC screening coverage:

- Remove coverage for the barium enema procedure;
- Add coverage for the computed tomography colonography (CTC) procedure (reassignment to status indicator 'S');
- Expand the existing definition of a "complete colorectal cancer screening" to include a follow-on screening colonoscopy after a Medicare covered blood-based biomarker CRC screening test;
- Delete HCPCS codes G0106 and G0120 (screening barium enema) effective December 31, 2024; and
- Modification**:** Reassign CPT code 74263 (screening computed tomography colonography (CTC)/virtual coloscopy) to APC 5523 (Level 3 Imaging Without Contrast) (proposed as APC 5522).

Table 141 contains the proposed and finalized list of covered CRC screening HCPCS codes.

Payment for Human Immunodeficiency Virus (HIV) Pre-Exposure Prophylaxis (PrEP) in Hospital Outpatient Departments

On July 12, 2023, CMS finalized the coverage of PrEP to prevent HIV under Medicare Part B, pending the final National Coverage Determination (NCD). This coverage, if adopted, would include HIV PrEP drugs, drug administration, HIV and hepatitis B screening, and individual counseling by either physicians or other health care practitioners. All components would be covered as an added preventative service without deductibles or co-pays. The final NCD was issued on Sept. 30, 2024. The finalized HCPCS codes for these services may be found in Table 142. The final decision memorandum for the NCD can be found here.

For CY 2025, CMS is finalizing payment for HIV PrEP drugs and services as additional preventive services under OPPS. Services listed in Table 144 that are furnished in HOPDs will be paid in a similar manner as to if they were furnished in a physician office. Drug products would be assigned to Status Indicator K and be priced using either the earlier finalized invoice pricing or the ASP/WAC methodology. If ASP data is unavailable, then CMS will calculate the payment amount based on the latest published value in the Medicaid National Average Drug Acquisition Cost (NADAC) survey, or if NADAC data is unavailable the Federal Supply Schedule (FSS). Alternatively, payment will be WAC+6%, or WAC+3% percent if in an initial sales period, in line with payment for separately payable drugs paid under the OPPS. In the case of drugs that are newly FDA-approved for HIV PrEP, CMS is requiring that hospitals billing for the drug must report the NDC for the product along with newly created HCPCS code J0799 to suspend the claim for manual pricing by the MAC. The claim will then be priced at 95% of the drug or biological's AWP.

Finally, CMS is implementing that, if covered as an additional preventive service, all HCPCS codes for pharmacy supplying fees related to HIV PrEP to a status indicator of 'B' (code not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x and 13x). These services will not be paid under OPPS.

Health Equity Quality Measures

CMS is adopting additional measures for use with the Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) programs, shown in the table below.

Measure	Programs Affected	Reporting Period	Payment Determination
Hospital Commitment to Health Equity (HCHE) Measure	OQR / REHQR	CY 2025	CY 2027
Facility Commitment to Health Equity (FCHE) Measure	ASCQR	CY 2025	CY 2027
Screening for Social Drivers of Health (SDOH) Measure	OQR / REHQR / ASCQR	CY 2025 (voluntary)	CY 2027
	OQR / REHQR / ASCQR	CY 2026	CY 2028
Screen Positive Rate for Social Drivers of Health (SDOH) Measure	OQR / REHQR / ASCQR	CY 2025 (voluntary)	-
	OQR / REHQR / ASCQR	CY 2026	CY 2028

Modification to the Immediate Measure Removal Policy for OQR and ASCQR

In the CY 2024 OPPS Final Rule, CMS adopted an immediate measure suspension policy for the REHQR program in lieu of an immediate measure removal policy for events where a measure raises patient safety concerns. CMS believes that the same rationale also applies to the Hospital OQR and ASCQR programs, and therefore is adopting, beginning CY 2025, to modify the immediate measure suspension policies for these programs so that they may be more appropriately referred to as immediate measure suspension policies.

OQR Updates

Hospitals that do not successfully participate in the OQR are subject to a 2 percentage point reduction to the OPPS market basket update for the applicable year. CMS is adding three new health equity measures, listed in the previous section, and one outcome-based measure to the OQR program. The outcome-based measure is 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/CY 2029 payment determination.

CMS is also adopting the removal of two measures:

- MRI Lumbar Spine for Low Back Pain measure beginning with the CY 2025 reporting period/CY 2027 payment determination; and
- Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery measure beginning with the CY 2025 reporting period/CY 2027 payment determination.

Regarding the three health equity measures being finalized for inclusion, CMS is finalizing that HOPDs will be required to submit all required data for the calculation of each measure annually using a CMS-approved, web-based, data collection tool available within the hospital quality reporting (HQR) system during the period of Jan. 1–May 15 in the year prior to that measure's use in payment determination.

For the Information Transfer PRO-PM measure, CMS is finalizing that HOPDs will be required to submit all required data for the calculation of each measure annually during the period of Jan. 1–May 15 in the year prior to that measure's use in payment determination. CMS will require that HOPDs offer all patients meeting the denominator specifications the opportunity to complete the survey, with a finalized minimum random sample size of 300 completed surveys used to ensure the reliability of the measure. HOPDs unable to collect 300 completed surveys will instead be required to submit data on survey responses from all completed surveys received.

Table 163 lists the 18 measures finalized to be collected for CY 2027 payment determinations. Table 164 lists the 19 measures to be collected for CY 2031 payment determination.

Beginning with the CY 2025 reporting period, CMS is requiring that electronic health record (EHR) technology be certified to all eCQMs available for reporting, and that HOPDs will be required to use the most recent version of the eCQM electronic measure specifications for the given reporting period, as available on the Electronic Clinical Quality Improvement (eCQI) Resource Center website.
In addition, to monitor the time psychiatric patients spend in the emergency department (ED) relative to other patients, CMS is finalizing to publicly display the Median Time for Psychiatric/Mental Health Patients stratum on Care Compare, beginning with measure data for the CY 2025 reporting period.

REHQR Updates

CMS is adopting the addition of three new health equity measures to the REHQR program, described above. Additionally, CMS is adopting a modification to the reporting period of the Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery Measure. CMS finalized increasing the reporting period for this measure from one year to two years beginning with the CY 2027 program determination. For CY 2027 determinations, this reporting period will be comprised of data from CYs 2024–2025.

For those hospitals converting to REH status, CMS is finalizing that these hospitals must begin submitting data to the REHQR program on the first day of the quarter following the date that a hospital converted to an REH.

To align with the OQR program, CMS is finalizing that for the three health equity measures for inclusion in the REHQR, REHs will be required to submit all required data for the calculation of each measure once annually using a CMS-approved, web-based, data collection tool available within the HQR System during the period of Jan. 1-May 15 in the year prior to that measure's use in payment determination.

Table 165 lists the four measures previously adopted for collection for CY 2026 program determinations. Additionally, Table 167 lists the seven measures finalized for collection for CY 2027 program determinations. Finally, Table 168 lists the seven measures finalized for collection for CY 2028 program determinations.

Medicaid Clinic Services Four Walls Exception

States may offer certain Medicaid benefits, including clinic services, at the individual determination of the state, to categorically needy and medically needy Medicaid beneficiaries. Federal Medicaid law prevents states from covering clinic care provided outside of the four walls of a clinic under Medicaid, barring an explicit exception.

In order to address concerns that CMS has heard from multiple parties, and to help states in strengthening and improving access to clinic services, CMS is adopting three additional exceptions to the four walls requirement.

- Clinic services furnished by IHS/Tribal clinics. Mandatory exception; facilities operated by urban Indian organizations (UIOs) will be excluded.
- Clinic services furnished by a clinic that is primarily organized for the care and treatment of outpatients with behavioral health disorders, including mental health and substance use (optional exception by state).
- Clinic services furnished by a clinic located in a rural area. Excludes RHCs; optional exception by state, with a finalized modification that a State must include a definition of rural area in its State plan that must be either a definition adopted and used by a Federal governmental agency for programmatic purposes, or a definition adopted by a State governmental agency with a role in setting State rural health policy.

Hospital Outpatient Department (OPD) Prior Authorization Process Timeframes

CMS currently requires prior authorization for the following services: blepharoplasty, rhinoplasty, botulinum toxin injections, panniculectomy, vein ablation, cervical fusion with disc removal, implanted spinal neurostimulators, and facet joint interventions. Upon receipt of the prior authorization request, the MAC issues a decision within specific timeframes.

CMS is adopting to change the current review timeframe for provisionally affirmed or non-affirmed standard review requests from ten business days to seven calendar days.

Provisions Related to Medicaid and the Children's Health Insurance Program

Continuous eligibility (CE) provides coverage protections for low-income children who are eligible for Medicaid or CHIP, which has shown to reduce financial barriers to accessing health care for low-income families, promote health equity, and provide states with better tools to hold health plans accountable for quality care and improved outcomes.

CMS is updating the Medicaid regulations to conform with changes to the CE policy implemented by the CAA of 2023. These changes specify that a state must provide CE for the specified period of time and removes the option to limit CE to those younger than 19 years of age. Furthermore, CMS is adopting the removal of the option to limit CE to a period of less than 12 months, as well as the option of ending a CE period for a person when they reach the state-specified maximum age.

CMS is also adopting the removal of the option for states to disenroll children from separate CHIP coverage for failure to pay required premiums or enrollment fees during a CE period.

Health and Safety Standards for Obstetrical (OB) Services in Hospitals and Critical Access Hospitals (CAHs)

Organization, Staffing and Delivery of Services

CMS will require new conditions of participation that if a hospital or CAH offers OB services outside of an emergency department (ED), those services must be well organized and provided in accordance with nationally recognized acceptable standards of practice for both physical and behavioral health care of pregnant, birthing, and postpartum patients. If outpatient OB services are offered, these services must be consistent in quality with those provided on an inpatient basis based on the complexity of services offered. In addition, CMS has finalized that the OB services offered be appropriate to the scope of those offered by the facility and integrated with other departments of the hospital. The OB service must maintain a list of practitioners that specifies the privileges of each. OB services delivered must be consistent with the needs and resources of a facility, including the availability of basic resuscitation equipment, a call-in system, cardiac monitor, and fetal doppler or monitor within the facility, consistent with the needs of OB emergencies, complications, immediate post-delivery care, and other patient health and safety events identified as part of a facility's Quality Assessment and Performance Improvement (QAPI) program.

Training for OB Staff in Hospitals and CAHs

Given the prevalence of health and safety concerns around maternal health outcomes, CMS is adopting a core set of requirements for facilities offering OB services in order to protect the health and safety of patients. CMS is thus finalizing that hospitals and CAHs with OB services be required to develop policies and procedures to ensure that relevant OB services staff will be trained on select topics for improving maternal care delivery, effective for the staff training requirement for hospitals is Jan. 1, 2027. These training topics will need to reflect the scope and complexity of services offered, including best practices and protocols to improve maternal care delivery. CMS finalized that facilities providing OB services use findings from their QAPI programs to inform staff training needs. A governing body must identify and document those staff that must complete an initial and biannual trainings, staff personnel records must contain information as to if the training was completed successfully, including the demonstration of staff knowledge and provide staff with initial training.

QAPI Program

CMS is finalizing that a hospital or CAH that offers OB services be required to use its QAPI program in order to assess and improve health outcomes and disparities among OB patients on an ongoing basis. This will mean that a facility, at minimum, will have to:

- 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 OB 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 OB patients; and
- Conduct at least one performance improvement project focused on improving health outcomes and disparities among the hospital's population(s) of OB patients annually.

CMS is also requiring that these hospitals' leadership (facility, OB services, or their designees) must be engaged in the facility's QAPI activities.

Emergency Services Readiness

CMS is finalizing that hospitals and CAHs that offer emergency services will be required to have adequate provisions and protocols to meet emergency needs of patients aligning with the complexity and scope of offered services. In addition, applicable emergency services personnel (as determined by the facility) will be required to be trained on these protocols and provisions annually. Once staff are identified, it is expected that the facility documents that the applicable staff members have successfully completed the training and have demonstrated knowledge on the topic. Finally, CMS is finalizing that emergency provisions include equipment, supplies, and medication used in treating emergency cases. These provisions must be kept at the hospital and be readily available, and must include drugs, blood and blood products and biologicals commonly used in life-saving procedures; commonly used life-saving equipment and supplies; and a call-in-system for each patient in each emergency services treatment area. CMS did not adopt a policy to extend these new Emergency Services standards to REHs.

Transfer Protocols

CMS is requiring that hospitals have written policies and procedures for transferring patients under their care. This will include transfers within the four walls of the hospital, as well as between different hospitals. CMS is also adopting that hospitals provide training to the appropriate staff regarding patient transfer policies and procedures with a modification that the requirements do not apply to CAHs and REHs.

Modification to the Hybrid Hospital-Wide All-Cause Readmission and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measures in the Hospital Inpatient Quality Reporting (IQR) Program

Based on hospital performance during the most recent voluntary reporting period, CMS has determined that hospitals appear unprepared for mandatory reporting of the Hybrid Hospital-Wide All-Cause Readmission and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measures under the Hospital IQR. CMS states that approximately one-third of IPPS hospitals participated during the voluntary reporting period, and other these, 75% will not have met the reporting thresholds for the core clinical data elements (CCDEs) and linking variables, and so will have received a 25% reduction to their annual payment update for the given fiscal year had reporting been mandatory.

Due to this information and in response to public comments, CMS is finalizing that the submission of CCDEs and linking variables remain voluntary for the FFY 2026 payment determination and the FFY 2027 payment determination to allow more time for hospitals to adapt.

Individuals Currently or Formerly in the Custody of Penal Authorities

Currently, Medicare is prohibited from covering any Part A or Part B expenses incurred for items and services furnished to an individual for which that individual or other person has no legal obligation to pay, except for FQHC services. This includes services furnished to individuals in custody of penal authorities (unless that prisoner is legally obligated to pay for such services). Currently, individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule.

CMS is finalizing the proposal that certain classes of individuals should no longer be presumed to be in custody for the purposes of the no legal obligation to pay exclusion. Thus, CMS is updating the definition of "custody," removing individuals who are under supervised release or required to live under home detention, and removing the phrase "completely or partially in any way under a penal statute or rule."

CMS has finalized that the rebuttal presumption that may be made if State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody will apply to all items and services furnished to individuals in custody, regardless of by whom they are provided.

Individuals required to live in a mental health facility are finalized to be clarified as only being in custody for purposes of the exclusion if required to live there under a penal statute or rule.

CMS is also adopting the definition of "penal authority", as a police department or other law enforcement agency, a government agency operating under a penal statute, or a State, local or Federal jail, prison, penitentiary, or similar institution for the purposes of the no legal obligation to pay exclusion.

CMS sought comment to determine when individuals who are required to reside in halfway houses should be considered in custody for the purposes of this exclusion. Based on comments received, CMS will not include individuals released from incarceration or confinement and transitioning to residence in halfway houses as being considered incarcerated or in confinement.
Lastly, CMS is updating the special enrollment period (SEP) eligibility criteria to account for these adopted policies and to align the criteria with the criteria used by the Social Security Administration (SSA) to determine whether an individual is incarcerated. CMS has specified that the SAP will start on the day an individual is released from incarceration on or after Jan. 1, 2025, as determined by the SSA, and will conclude on the last day of the 12th month following the month of their release, Additionally, individuals released from incarceration or confinement and transitioning to residence in halfway houses are not considered incarcerated or in confinement for the purposes of this SEP.

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