National Rural Health Association

Calendar Year (CY) 2025 Hospital Outpatient Prospective Payment System Final Rule

On November 1, 2024, the Centers for Medicare and Medicaid Services (CMS) released its CY 2024 Outpatient Prospective Payment System (OPPS) final rule.

For more information, see the summary below or find CMS' fact sheet here. If you have any questions, please contact NRHA's Government Affairs and Policy Director Director Alexa McKinley Abel (amckinley@ruralhealth.us).

Key provisions:

Payment policies. CMS is finalizing a 2.9% payment update for OPPS hospitals. This is higher than the proposed 2.6% increase. NRHA is pleased to see that CMS finalized a higher payment update than originally proposed. Rural hospitals will see closer to a 3.2% update.

CMS also updated payment for Intensive Outpatient Program (IOP) services. Hospitals and rural health clinics (RHCs) will be paid $272.46 for 3-service days and $413.50 for four or more services per day.

CMS is finalizing its proposal to pay an add-on to the all-inclusive rate (AIR) to Indian Health Service and tribal hospitals for all drugs administered whose per day cost exceeds two times the Medicare Outpatient per Visit Rate for the lower 48 states' AIR ($1,334 in CY 2024).

Obstetric services conditions of participation (COPs). NRHA is disappointed that CMS moved forward with finalizing new COPs for obstetric (OB) services at hospitals and critical access hospitals (CAHs). CMS did not extend these requirements to rural emergency hospitals (REHs). CMS largely finalized the COPs as proposed but gave hospitals and CAHs a longer timeframe for compliance. This includes:

- **Effective January 1, 2026:**
  - All labor and delivery rooms and suites must be supervised by an *experienced* registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a physician.
  - OB privileges must be delineated for all practitioners providing OB care in accordance with the competencies of each practitioner.
  - OB services must be consistent with the needs and resources of the hospital or CAH. This includes:
    - A call-in-system, cardiac monitor, and fetal doppler or monitor must be kept at the hospital or CAH and readily available. CMS amended this language from the proposed rule in response to NRHA concerns and now the equipment only needs to be at the hospital or CAH.
    - There must be adequate provisions and protocols, consistent with nationally recognized and evidence-based guidelines, for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified as part of the QAPI program.
- **Effective January 1, 2027:**
  - The hospital or CAH must develop policies and procedures to ensure that relevant staff are trained on select topics for improving the delivery of maternal care.

- Training concepts must reflect the scope and complexity of services offered within the facility, including but not limited to facility-identified evidence-based best practices and protocols and the hospital or CAH must use findings from its quality assessment and performance improvement (QAPI) program.
- The hospital or CAH must provide relevant new staff with initial training.
- The governing body must identify and document which staff must complete initial training and subsequent biannual training on the topics identified.
- The hospital or CAH must document in the staff personnel records that the training was successfully completed.
- The hospital or CAH must be able to demonstrate staff knowledge on the topics identified.

Quality Assessment and Performance Improvement (QAPI) Program COPs. CMS amended QAPI COPs for hospitals and CAHs. CMS did not extend these requirements to REHs. **Effective January 1, 2027, for hospitals and CAHs that offer obstetrical services:**

- Obstetrical services leadership must engage in QAPI for obstetrical services, including but not limited to participating in data collection and monitoring.
- If a maternal mortality review committee (MMRC) is available at the State, Tribal, or local jurisdiction in which the hospital is located, the facility leadership, obstetrical services leadership must further have a process for incorporating publicly available MMRC(s) data and recommendations into the QAPI program.
- Hospitals must utilize their QAPI program to assess and improve health outcomes and disparities among obstetrical patients on an ongoing basis.

Amended emergency services COPs. In addition to OB specific COPs, CMS is finalizing its proposal to amend emergency services COPs to add provisions around "emergency services readiness." These apply to all emergency services broadly, not just OB emergencies. CMS did not extend these requirements to REHs. This includes, for both hospitals and CAHs:

- **Effective July 1, 2025:**
  - There must be adequate provisions and protocols to meet the emergency needs of patients.
  - Protocols must be consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with OB emergencies, complications, and immediate post-delivery care.
  - Applicable staff, as identified by the hospital, must be trained annually on the protocols and provisions around emergency services readiness.
    - Hospital leadership must identify and document which staff must complete training.
    - The hospital must document in the staff personnel records that the training was successfully completed.
    - The hospital must be able to demonstrate staff knowledge on such training.
    - The hospital must use findings from its QAPI program to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis.

Supervision of certain services. CMS will allow nurse practitioners, physician assistants, and clinical nurse specialists to provide direct supervision for cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation. This includes virtual presence using audio/video real-time communications technology (excluding audio-only) through December 31, 2024.

Prior authorization. CMS is shortening its timeframe for standard prior authorization requests for certain covered outpatient department services from 10-business days to 7-calendar days. This only applies to Traditional Medicare, not Medicare Advantage.

Medicaid clinic services. Federal reimbursement for Medicaid clinic services is limited to services furnished within the "four walls" of the clinic except for the treatment of homeless individuals.

CMS finalized its proposal to add exceptions to the four walls requirement, including an exception for clinic services furnished by a clinic located in a rural area. This does not include RHCs, which can already provide services covered under a separate Medicaid benefit. CMS is finalizing this exception and allowing states to choose a definition of rural area that is 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.

The other two exceptions are for IHS/tribal clinics and behavioral health clinics.

Continuous eligibility. CMS is codifying the requirement from the Consolidated Appropriations Act of 2023 to provide 12 months of continuous eligibility to children under the age of 19 in Medicaid and CHIP.

Quality reporting programs. CMS is finalizing changes to both the Rural Emergency Hospital Quality Reporting Program (REHQR) and Hospital Outpatient Quality Reporting Program (OQR).

- For both the ORQ and REQHR programs, CMS is adding:
  - Hospital Commitment to Health Equity measure beginning in CY 2025 reporting/CY 2027 payment year.
  - Screening for Social Drivers of Health measure
    - Voluntary reporting in CY 2025, mandatory reporting in CY 2026 payment/CY 2028 payment year.
  - Screen Positive Rate for SDOH measure
    - Same reporting schedule as above.
- For the OQR program only:
  - Adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure.
  - Remove the MRI Lumbar Spine for Low Back Pain measure beginning with the CY 2025 reporting period/CY 2027 payment year.
  - Remove the Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery measure.
  - Require electronic health record (EHR) technology to be certified to all electronic clinical quality measures (eCQMs) available to report beginning with the CY 2025 reporting period/CY 2027 payment year.
  - 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.
- For the REHQR program only:
  - Extend the reporting period for the Risk Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery measure from one year to two years beginning with the CY 2027 program determination.

- Clarify that data reporting to REHQR begins on the first day of the quarter following the date that a hospital has been designated as converted to an REH.

Virtual direct supervision. Through December 31, 2025, hospitals may continue to utilize virtual direct supervision of cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation services.