Healthcare Regulatory Round-Up #82 Webinar Transcript

2025 Hospital Outpatient Prospective Payment System (OPPS) Final Rule

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SPEAKERS

Martie Ross, Kathy Reep, PYA Moderator

SUMMARY KEYWORDS

Hospital Outpatient Prospective Payment System, OPPS, Medicare payment rates, outpatient quality reporting, maternal health conditions, social determinants of health, SDOH, emergency services protocols, staff training, observation status appeals, Medicare change of status, patient appeal rights, QAPI requirements, rural emergency hospitals, budget neutrality adjustment, wage index reductions, diagnostic radio pharmaceuticals, non-opioid pain relief, Conditions of Participation, COPs, Medicare Physician Fee Schedule, Quality Assurance and Performance Improvement, ESRD

WEBINAR SUMMARY

The 2025 Medicare Hospital Outpatient Prospective Payment System Final Rule was discussed, highlighting a 2.9% rate increase to $89.17 per visit. Key changes include new services added to the inpatient-only list, such as liver allograft services, and new payment provisions for non-opioid pain relief post-surgery. Quality programs now include measures for social determinants of health, with a focus on health equity and screening for social drivers. New maternal health conditions of participation were detailed, emphasizing emergency services readiness, transfer protocols, and staff training. The Medicare patient status appeals Final Rule was also covered, addressing appeal rights for patients reclassified from inpatient to outpatient observation status.

The webinar covered the 2025 Medicare Physician Fee Schedule Final Rule, focusing on ten key topics:

1. 2025 Medicare Hospital Outpatient Final Rule overview
2. Payment rate increases and adjustments
3. New Services on Inpatient Only List and Psychiatric Programs
4. Quality Program Changes and Social Determinants of Health.
5. Maternal Health Conditions of Participation.
6. Emergency Services and Transfer Protocols
7. Obstetrical Services and Staff Training

8. Quality Assurance and Performance Improvement (QAPI) Program
9. Medicare Patient Status Appeals Final Rule
10. Implementation and Next Steps

ACTION ITEMS

- ☐ Develop protocols and provisions for emergency services that reflect nationally recognized, evidence-based guidelines.
- ☐ Maintain written policies and procedures for transferring patients to appropriate levels of care.
- ☐ Engage in QAPI activities to assess and improve OB health outcomes and address disparities.
- ☐ Provide Medicare Change of Status Notification to patients reclassified from inpatient to outpatient observation.

TRANSCRIPT

PYA Moderator **00:01**

Thank you for joining us. The webinar will begin shortly.

Good morning, everyone. Welcome to the latest episode of PYA is healthcare regulatory roundup Webinar Series. Today's topic is the 2025 Medicare hospital outpatient, prospective payment system, Final Rule. PYA is happy to present today's webinar on this important topic.

You may submit questions during the webinar by typing a message into the questions pane of the control panel. Also, immediately following the end of the webinar, you'll be asked to complete a short survey and submit any additional questions. We'll respond to questions posed after the webinar via email. We've posted in the handouts pane of the control panel a PDF copy of the slides for your reference. Also, you'll receive an email later today with a copy of the slides and a recording of the webinar.

With that, I would like to introduce our presenters, Martie Ross and Kathy Reep.

Martie Ross **00:53**

Thank you, Jennifer. Good morning, everyone. Thank you for joining us today. Back on November 1 CMS released the four payment rules based on calendar year. That's ESRD, home health, Medicare, Physician Fee Schedule and hospital outpatient regarding ESRD, very briefly, CMS increased the base rate just by a few cents in the final rule for home health it was probably great news for home health agencies. They went from what would have been about a 1.7% reduction in payment rates as compared to 2024 to what now will be about a half percent payment increase for home health agencies, the Medicare Physician Fee Schedule, which is always a monster of a rule included numerous provisions, including the expected reduction in the conversion factor.

Starting next week, on November 20, we're going to do a three-part webinar series that will provide a deep dive into numerous provisions within the Medicare Physician Fee Schedule. But for today, our focus is going to be on that fourth rule, the Hospital Outpatient Prospective Payment System rule, or OPPS. So

specifically, Kathy's going to start us out discussing payment rates as well as other payment related provisions in the OPPS rule. I will drill down on the quality program related provisions, as well as the new maternal health conditions of participation. And then, as a bonus, Kathy is going to introduce the Medicare Patient Status Appeals Final Rule, which had been released in October, which will have some immediate impacts as that appeals process is stood up.

So, with that, Kathy, I'm going to turn it over to you.

Katy Reep **02:42**

Thanks, Martie. Let's go on to the next slide, and let's just talk, start talking money. That is in order for us to talk address the things Martie's going to talk about, we got to talk about the reimbursement that we're going to be getting. Essentially what we're looking at, we had a proposed rule that had a 2.6% increase proposed for under the outpatient system, we got a final rule with a 2.9% rate increase over 2024 so the payment rates that we're looking at for 2025 are going to be somewhere close to $89.17 as opposed to the $87 and nearly 40 cents that we have right now. So that is an increase in the base rate for all providers paid under the Outpatient Prospective Payments System.

One thing that we need to recognize is that if you are a provider who did not meet the outpatient quality reporting requirements, then you're going to have a two-percentage-point reduction in that base rate. So you're not going to be getting a 2.9% increase. You're going to be getting point nine The other thing to recognize is that when we look at that rate increase that the hospitals receive. There are a number of adjusters, not just the market basket of 3.4 less a point 5% statutorily required productivity adjustment, but we also have some other adjusters that come into play that impact your overall reimbursement such as we've got the budget neutrality adjustment. We've got the cap on wage index reductions. Again, remember, CMS doesn't allow an area wage index to drop more than 5% from one period to the next. So those all come into play when we are looking at that $89.17 cent payment rate for the most part, CMS used 2023 claims data and 2022 cost report data. That was the most recent data that was available, although they did not have a full 20. 2022 cost data, just literally because of the ongoing process to finalize cost reports, we know that ambulatory surgical centers are paid under the Outpatient Prospective Payment System. They are paid 60% of the OPPS rate. So just like hospitals who are going to receive that 2.9% increase in the base rate, the plans will also receive a 2.9% increase in their rate. And if they are not reporting the under the ASC quality reporting requirements, they too would see that 2% reduction in their rate to a total of point nine. So they parallel OPPS, but that's 60% of the actual payment rate.

Next slide. Wanted to take a look at a few provisions, just a few that impact payment that are perhaps fairly new for providers. The first one obviously isn't the inpatient only list. What we have in 2025 is three new services added to the inpatient only list. These are going to be liver allograft services, and they are removing from the inpatient only list, the pelvic fixation So recognize that if you are within your system, you are tracking that IPO list, you need to take two to 848, out, but add in the liver allografts moving forward On the next slide. Just wanted to touch very briefly on the intensive outpatient and the partial hospitalization services. These are psychiatric programs that are covered under the Medicare program on an outpatient basis. I've given you the payment rates for the partial hospitalization and the intensive outpatient programs based upon whether they're provided in a hospital outpatient department or in a community mental health center, giving you the rates, you will have the slides for review. But the most

important thing, I think, for me to stress is that there were no billing or coding changes for either the intensive outpatient or the partial hospitalization programs, we continue to bill with the same codes as we were doing in 2024, couple of other items that are going to impact reimbursement, diagnostic radio pharmaceuticals. CMS has identified those ready diagnostic radio pharmaceuticals with a per day cost of greater than $630 that $630 will change annually, but CMS has decided to pull those um pharma radio pharmaceuticals out from the weight of the APCs, they and they will be reimbursed based upon their mean unit their mean unit cost, using hospitals claims data to calculate that. So if you are if it, if it had, if it is a diagnostic, radio pharmaceutical with a cost below 630 it's going to continue to be packaged, but if it is one with a with a per day cost greater than 630 then you will be receiving additional reimbursement for those outside of the APC For the Nuclear Medicine Service and on the next slide, another opportunity for providers. And this is a provision that was under the Consolidated Appropriations Act of 2023 this is going to be for separate payment for non-opioid treatment, for post-surgical pain relief. When we had the proposed rule on this. There were a number of drugs and biologicals that were proposed to be covered under this program.

As we move into the final rule, we actually are now going to have both qualifying drugs and qualifying medical devices that can be used for pain relief for a patient following surgery. This will be both in the outpatient hospital setting and in the ambulatory surgical centers, center section settings. And the program is expected to run from 2025 through 2027 we will be using new status indicators to indicate whether or not this is a non-opioid drug and biological or a non-opioid medical device. But there are six drugs, five medical devices and therapies that have been approved for separate reimbursement moving forward into 2025.

Martie Ross **10:03**

Let's talk. Let's leave the world of payment, and let's talk about changes that have been made to the quality programs for hospital outpatient ambulatory surgery centers as well as the rural emergency hospital program across all three of those programs, CMS is adding new measures specifically addressing social determinants of health, beginning with the commitment to health equity measure. This will sound familiar because this measure was added on the hospital inpatient Quality Reporting Program this year.

So, beginning in 2025 and that's impacting payment, in 2027 hospitals will be required to provide the attestation relating to the organizational commitment to health equity. That attestation is across five specific domains, including equity as a strategic priority, data collection activities, data analysis, quality improvement around health equity, and leadership engagement in health equity issues, similar to the IQR program, the hospital we expected to sign the attestation through the portal indicating that in fact, the hospital is engaging in these specific activities as defined within the measure.

Second new measure is the screening for social drivers of health measure, again, one with which you will be familiar because it is now part of the hospital IQR program. This is a little bit longer runway in terms of implementation. CMS will accept voluntary reporting for calendar year 2025 but the measure will become mandatory in 2026 thus impacting 2028 payment. We always have that two year drag report. If you fail to report, it's going to impact your payment two years down the road. So for example, in 2025 you're getting that negative payment adjustment that Kathy discussed, based on whether you reported all the required measures. In 2023 regarding screening for social drivers of health, you will be reporting on

the number of adult patients who received care in a hospital outpatient department, a rural emergency hospital or an ambulatory surgery center, who were screened at the time of service for specific health related social needs, the required needs of which you will be screening for include food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. Again, you are able to use a self-selected tool in performing these screenings, but at the end of the day, the critical reporting number is the number of adult patients for whom you've completed screening note, when we refer to hospital outpatient department, we are including physician practices that operate as ho PDS, many of us anticipate that within the next couple of years, we will see a similar type of measure as part of MIPS, and this almost seems like the first attempt to get into that issue of completing these screenings within the physician practice setting, since we have that opportunity now with the HOPD reporting.

Finally, the next measure coming online with a similar type of ramp up with the voluntary reporting in 2025 mandatory in 2026 will be the screen positive rates for the SDOH is so not only reporting the number of individuals for whom you performed the screening, but then the number of adult patients who received those screenings, who screened positive for one or more of those health-related social needs. So, you're going to report separately for each hrs in indicating the number of positive screens. Again, note that this is these measures are across all three quality programs that are considered part of the OPPS final rule. So, this is implemented in the hospital outpatient setting. It will be implemented in the ambulatory surgery center. So we're adding screening for procedures performed AFCS. But also, this is a new quality reporting requirement for our rural emergency hospitals, if you'll recall, as part of the Consolidated Appropriations Act 2021, Congress created a new classification of Medicare provider, the rural emergency hospital, which is a facility that does not have inpatient services, but instead provides hospital outpatient and emergency services within their community. The. Are reimbursed based on OPPS, but with a kicker, they get a 5% additional bonus payment as an REH in addition to a monthly facility fee that is paid to the REH as well.

We've had about 25 hospitals that have converted to REH. There are no de novo RHS, you have to convert from either a critical access hospital or a PPS hospital with 50 or fewer beds. CMS has been building the Quality Reporting Program for re HS as it's been developing the full regulatory scheme. There were initial quality reporting requirements that were released last year, so now we're adding to that list with these new quality reporting around commitment to health equity and screening for social determinants of health in the OPPS world. In the ASC world, remember, failure to report is that 2% adjustment. There is no technical penalty to re ages. It does not impact their payments if they fail to report, but CMS has indicated that it will potentially have ramifications on certification with Conditions of Participation going forward if hospitals fail to engage in the reporting required under their hospital under their reporting program.

Other changes made to the oops, sorry I got excited there. Try to jump ahead to the new COPs. But other changes to the individual Quality Reporting Program. So, for the outpatient Quality Reporting Program, you see new a new measure being added for 2026 reporting, which is the patient understanding of key information related to recovery after facility-based procedure or surgery.

That just rolls off the tongue, doesn't it? Kathy, I'm sure there's going to be an acronym we will use for that, but that is a measure that will be introduced for again. Volunteer reporting in 2025 mandatory in 2026 there are three measures that are being removed from the list of required reporting. And then there will be a new measure also added for reporting on excuse me, there'll be one measure added the three measures removed, and then CMS is escalating the status of the median time from emergency department

parcher arrival to emergency department emergency department departure for psychiatric and mental health patients.

We've been reporting on that measure, but now we're going to elevate that to one of the measures that is specifically reported out by hospital on care compare so if an individual goes on the care Compare website, pulling up information on their local hospitals, one of the measures they'll see specifically reported on that care Compare website is this median time from arrival to discharge for these specific types of patients in the ambulatory surgical Ambulatory Surgical Center Quality Reporting Program, no specific changes to the program beyond those we just previously discussed, except that there is a request for information included on changes to data reporting requirements related to case volume.

So how many cases do you have to perform to actually? Then have to report on a corresponding measure. And CMS is saying looking for additional information from stakeholders on where those cut off should be set, and then for the rural emergency hospital Quality Reporting Program, two clarifications here, extending the reporting period for the risk standardized hospital business within seven days of a hospital outpatient surgery. Again, another title that just rolls off the tongue, but changing that from what had been a one-year reporting period to a two-year reporting period. Again, not surprisingly, the theory here is that we want to have an adequate volume of procedures so that it's a meaningful measure. When reported anticipating that for most rural emergency hospitals, relatively small number of surgical procedures annually, we're going to get a much more accurate reading if we're looking at that period over two years. And then finally, CMS clarify that the commence your data. When would you begin submitting data? When do you start counting data for purposes of reporting under the REH program? And they clarify that it will be the first day of the quarter following your conversion to REH. So if you, for example, your conversion was effective on March 17, not that that's the date that all the COVID 19 stuck in my head, because it's the date of the COVID 19 flexibilities. But say you converted on March 17, so your quality of reporting would then begin on. Do the math, April 1. Right, right? Because that would be the next quarter going forward. So, there are the changes to those programs. The big heavy hitter, the new thing in the OPPS rule are these new maternal health conditions of participation. In fact, if….

Kathy Reep **20:13**

You sit so well in an outpatient rule….

Martie Ross **20:16**

Well exactly, and that's the point Kathy is, where this started, if you'll remember, was in this year's proposed inpatient PPS rule CMS included an RFI a request for information regarding approaches to the maternal health crisis through the addition of new conditions of participation for hospitals and critical access hospitals. And at the time, we thought, okay, very nice. RFI, they'll get some information back. We'll circle around the beginning of 2025 when we get a proposed inpatient, prospective payment system rule for 2026 and that's where we'll see these new COPs.

Surprise, when we opened up the proposed rule, OPPS proposed rule in July. We see that, in fact, CMS had a very extensive proposal for new maternal health related conditions of participation. There were, surprisingly, not that many comments. Kathy, I think it was like 150 total comments that CMS received on the COPs, but they many of which said, please delay the effective dates, and we'll talk about how they

responded to that here in a second. But they have finalized the rule going forward with specific implementation dates and, of course, promises of sub regulatory guidance in the near future to assist providers in their compliance. But again, if you look at the rule and again, we're dealing right now with the public inspection copy. CMS will publish the OPPS final rule in the November 27 Federal Register. But I would say a good third of the rule is devoted to discussing these COPs, going through the comments that they received these COPs, and again, promising more sub-regulatory guidance; but there was a very lengthy section in the final rule discussing the US maternal health crisis. I thought it was worth kind of teasing out a few of the key statistics which we need to be reminded of regularly, beginning with the fact that in 2022 there were 22 maternal deaths per 100,000 live births, the hard number to get your head around in the abstract, but compare our rate to other industrialized countries, where there are fewer than nine deaths per 100,000 so we're more than twice the rate of maternal deaths in the United States. The other issue is significant variation among the states. So, if you compare the state with the highest maternal death rate to that state with the lowest, you'll find that the highest rate is four times the lowest rate. So, we have some pretty significant inequities based on geography. When we get to the issue of maternal health. CMS notes that the expert commentary is that about 80% of maternal health are maternal health. Maternal deaths are preventable if individuals receive the right care at the right time. 25% of all maternal deaths occur within at the time of delivery, or within six days following the end of pregnancy. So yes, we have the measure, the maternal death rate measure is a year is a year measure, so from the time of pregnancy complications and then one year post delivery. But they're saying that up those measured maternal deaths, we see 25% of them occurring within either at the time of delivery or within six days thereafter. And CMS says that's our justification for moving forward with these maternal health COPs, because we know that that opportunity for intervention in those cases is at the hospital level, and so we think this is where we can have a significant impact.

Also, discussion of the inequities in maternal deaths, noting that maternal morbidity for minority women is two to four times higher than the rate for white women, and that women in rural communities are about 60% more likely to die before, during or following birth than their urban counterparts. So, it isn't hard to make the case that we have a significant issue on our hands, and CMS is willing to pull any and all levers available to it, and that includes the publication of these new conditions of participation. There were several comments received by CMS along the lines of, these are not these COPs are enough to really address the maternal health crisis. And to which CMS said, you're absolutely right. But these are one tool we have available to us, and we're going to use every tool in the toolkit, so that includes monitoring how the efforts hospitals are making to address the maternal health crisis.

So, what we have now are changes to both the hospital conditions of participation as well as the critical access hospitals of participation. If you're familiar with the two sets of regulations, the hospital rules, not surprisingly, are more involved the critical access hospitals are sort of a slimmed down version of the hospital Conditions of Participation, but you'll see in this final rule, new regulations impacting both sets of rules, beginning with a new condition of participation that establishes baseline standards for obstetrical services. So, we have COPs, for example, that talk about emergency services and surgical services and radiology services. These are all referred to as optional services offered by hospitals. Now, at a base, a hospital provides inpatient services, but when they or these additional types of services, they are required to adhere to the condition of participation governing that type of service. Now, similarly. Now we're adding obstetrical services to that list of optional services for which there are specific baseline standards now being added. CMS repeats several times throughout the final rule that these new COPs are not

dictating standards of care, or otherwise requiring hospitals to offer any specific type of care to patients, but instead, the mandate is that the baseline should adhere to the needs of the hospital based on the population it's served based on the services it makes available, and based on best practice and evidence based standards.

In addition to adding that new COP specific to obstetric services, CMS is also updating the Quality Assurance and Performance Improvement COPs, the QAPI COPs, one of my favorite acronyms, but now to include very specific requirements with regard to OB, OB-related activities, so using QAPI activities to improve your care maternal health services, third up as our updates to the hospital discharge planning conditions of participation to include transfer protocols. CMS notes that for critical access hospitals, there are already specific COPs that address patient transfers between facilities, and now we're adding a specific requirement now for hospitals regarding transfer protocols.

And finally, updates to the emergency services Conditions of Participation to include specific protocols, provisions and training requirements. Important to note that, with the exception of the update to emergency services COPs, these requirements are only applicable to those hospitals and critical access hospitals that provide OB services outside their emergency department.

In the proposed rule CMS, so there were about 5700 PPS hospitals that currently provide OB services. There are about 500 critical access hospitals that provide those services. About 38% of all critical access hospitals now have formal OB programs. So those first three COPs that I referenced, those are all those are only going to apply to hospitals with OB services. But number four, which is the update to emergency services COPs, that applies across the board to all hospitals, all critical access hospitals, regardless of whether you have a formal OB program as referenced, CMS responded to a number of comments asking for delays in actually the effective dates of these rules by adopting a phased in approach.

So the first of these rules will become effective on July 1, 2025 so you should be in compliance with the COP by that date, that is for the emergency services, readiness COPs, the ones that apply to everybody, as well as the hospital adoption of transfer protocols. And again, I made a mistake. I misspoke Kathy, because the hospital Transfer Protocol requirements also apply to all hospitals, not just those with OB programs. Then for we went the beginning of next year's next year, I guess, January 1 2026 is when the baseline standards for OB services will be effective, with the exception of OB staff training requirements. And then another year, January 1 of 2027 is when those OB staffing training requirements will become effective, as well as the requirements regarding Quality Assurance and Performance improvement programs.

Okay, so let's drill down a bit. Let's talk about these different COPs, and let's put them in the order of their effective date, so you can figure out the priorities in your head. So starting with the updates the emergency services comp. Services again, compliance required by July 1 of 2025, applies to all hospitals and all critical access hospitals.

Martie Ross **30:11**

First, the new COP requires that the hospital and critical access hospitals maintain protocols that are consistent with the complexity and scope of the services they offer that reflect nationally recognized,

evidence-based guidelines for the care of patients with emergency conditions this cop, these COP requirements are not specific to OB. They are, in fact, broader and deal with all emergency conditions, although OB emergency conditions are specifically called out in in the text of the rule, when we refer to OB emergencies, we are including both complications and immediate post-delivery care in the discussion, in the final rule, CMS sets forth the standard by which it will evaluate hospitals and critical access hospitals compliance by noting that a facility must be able to articulate their standards and the sources.

So why did you choose the rule and what were you basing it on? As well as being able to demonstrate that the standards they've adopted are based on evidence and nationally recognized sources. So this is not just a matter of typing up a protocol of how we're going to handle different types of emergency conditions. It is, in fact, the requirement that you research best practices and develop your protocols consistent with appropriate evidence-based guidelines, and be able to cite chapter and verse as to the source of the provisions that you have included within your protocols. So it is more than just sort of the standard adopt a policy and procedure. It is, in fact, a charge to hospitals to ensure that they are practicing consistent with the best evidence at the time. This is not just a one-time implementation. This is an ongoing obligation to ensure that these protocols are remain consistent with advances in evidence-based practice.

Secondly, this COP requires that that hospitals and cause maintain adequate provisions, ready, readily available to treat emergencies that would include appropriate equipment, supplies, drugs, blood and blood products and biologics that are commonly used in life saving procedures. Now go look at the rule. There's no specific checklist on what you have to have. Instead, it's more of this right sizing directive. Tell us, based on the volume of cases, the types of cases that present to your emergency department, what do you consider the minimum standard of what's necessary to provide those services, there is one specific requirement included, which is that you have to have a call-in system for each patient in each emergency services treatment area. A call-in system is just a way that the patient or a caregiver can communicate with the providers while in that emergency services treatment area, so it doesn't have to it could be low tech or it could be high tech, depending on your specific needs. CMS specifically require promises, clarifications, and some future sub regulatory guidance on this particular issue.

Third requirement within the emergency services COPs, and the one that is going to cause you the most pain is you requirement to train applicable staff annually on those protocols and provisions and very specific requirements with respect to these trainings. First of all, it falls to the governing body to identify and document the staff to be trained so who within your hospital is engaged in providing emergency services for those of the individuals that you want trained on these protocols and provisions, the governing body can delegate to a management to actually identify those individuals by position, but importantly, the governing body retains responsibility for ensuring that that is done and done appropriately. Secondly, it's a little bit of the cart before the horse here, but your training needs to reflect and be informed by your Quality Assurance and Performance Improvement Program findings. Now, as you'll recall, the copy requirements specific to OB don't become effective until 2027 but you're now doing training in 2025 obviously, this is reflective of the more long-term annual training requirements. So this would not be something specific to this initial training you'll be conducting over the next few months. Third up is that you have to document successful completion of training in your staff personnel records. So I should be able to look up a particular staff person. I should be able to pull their personnel records, and I should see their documentation of their completion of these emergency services training. And finally, the expectation that the hospital must be able to demonstrate staff knowledge on training topics.

So what is the vehicle by which you can show that folks who attended this training actually learned something, you know, as opposed to, you know, turning on the streaming training program and doing something else while the time clicks by. What's your vehicle for, ensuring that the individuals who participated in the training actually learned something. Is it? Is it? Post course testing, for example, or some other vehicle, again, not prescriptive here in the methodology to demonstrate staff knowledge, but just the fact that you have in fact done something to be able to ensure that patient, that the, excuse me, the personnel have received, and are in fact aware of the information that you receive.

So here's the here's the rub. They gave us six months, but within that six-month period, you've got to do the research to develop the protocols and have those protocols implemented. You've got to do the analysis to determine what are the minimum and adequate provisions to provide emergency services, and again, not just OB This is brought to all emergency conditions. And then you have to train all the staff on those protocols and provisions and have that documented in their documented their personnel record by a compliance date of July one of 2025, so there is a significant amount of work to be accomplished in a relatively short period of time, even given this delayed implementation date six months out.

Kathy Reep **37:14**

And as you said, it's not just trained but demonstrating knowledge of that training. And then we've got to go back to the board as well, to at least delegate to someone to identify the appropriate staff. So…

Martie Ross **37:27**

Yeah, and if your board's only meeting every other month, and they meet in December, and you're not going to see them begin till February, this certainly is going to have to be part of that agenda for that meeting, because that critical approval component of defining the scope of this training program on emergency services.

Well, with that good news, let's move on to the next one, the hospital discharge planning comp, also with the July one of 2025, date, again, I apologize I misppoke. This requirement is going to apply to all hospitals, regardless of whether you have OB services outside the ED again, because these emergency services COPs, changes are applicable to all emergency conditions, not just OB. Keep in mind again, this is note for critical access hospitals, rules are not changing. You're going to the current COVID talks about transfer protocols will remain in effect and does not there's no changes to that rule. But the expectation here is that hospitals maintain written policies and procedures for transferring patients to appropriate levels of care promptly and without delay to meet specific patients' needs.

So what do we need by transfer? There are three different levels of transfer here, referenced in the final rule. These are transfers from the emergency department to an inpatient admission. So how do we get an individual from the ed to a bed on an inpatient floor? What's our process for accomplishing that? Secondly, transfers between inpatient units of the hospital. So how do you go from intensive care down to a regular inpatient floor, for example? And third, and what you typically think of when I say transfer is inpatient transfers to a different hospital. So either moving a patient to a higher level of care or bringing a patient down from a higher level of care to a facility closer to their community to complete their inpatient stay and get how do you arrange for those transfers? How do you actually physically accomplish those transfers? Those should be reflected in those written policies and procedures.

Next up is providing annual training to relevant staff regarding those policies and procedures for patient transfers, again, the idea of identifying the relevant staff and then tracking who receives those training. Interestingly, the commentary on this particular COP in the final rule does not go into the level of detail that you see on that training for emergency services. Assuming again that this would be a more limited number of individuals who would be participating in this training. CMS notes that there are many other complimentary policies that a hospital may want to adopt. In fact, they encourage hospitals stop including development of policy and procedures on acceptance of transfers, encouraging hospitals to develop collaborative relationships, to facilitate a regional continuum of care and to foster relationships with birthing facilities in your community. Again, noting that the rules don't reach these three specific circumstances, but CMS does comment that they see this as an opportunity for future rulemaking. So as you're looking at this issue holistically within your organization, you want to broaden the conversation to include those topics as well.

Next up the let's talk about the COPs for obstetrical services. Again, these are, this is a whole new condition of participation applicable to those hospitals and critical access hospitals that provide obstetrical services outside the emergency department. And you can break these COPs into three categories, okay, there are requirements regarding organization and staffing. There are the requirements regarding delivery of services, and there are the requirements regarding staff training, the first two organization and staffing and delivery of services. The compliance date is January 2026 according to organization and staffing for excuse me, three specific requirements here OB services need to be integrated with other departments of the hospital, because OB patients often require whether it's imaging services or surgical services, but to have clean lines of communication between OB and those other departments of the hospital.

Second is OB facilities must be supervised by an experienced physician, non-physician practitioner, or are in again, this is reaching down to our critical access hospitals as well beating facilities. When we say the facilities are being supervised, that is a reference to physical presence, so having an individual available to supervise those services. And finally, a requirement that OB privileges must be delineated for all practitioners based on their competencies. So is this person competent to do, you know, a vaginal birth after C section, for example. Do they have that training and skill set to do that? CMS notes, again, in the final rule that if you are, in fact, presently complying with the medical staff Conditions of Participation regarding privileging you by default, are complying with this new requirement within the OB COPs as well, regarding delivery of services and again, January 1 2026, compliance date here, hospital needs to adopt provisions and protocols for OB emergencies, complications, post-delivery care, as well as other health and safety events, consistent, again, with nationally recognized evidence based guidelines. So similar to what we're doing for emergency services, this idea of developing the protocol, Identifying the provisions, and being able to demonstrate the basis for why you adopted that particular standard. So having those citations and footnotes, shall we say, to the protocols and to those list of provisions that we adopt, here, we have a little bit of prescriptive language in one of the COPs CMS notes that for again, treatment, OB treatment areas. I said that wrong at a minimum CMS is going to require that there be a call-in system, cardiac monitor, and either a fetal Doppler or monitor must be readily available in the area where OB services are being provided. The proposed rule had used the language in every OB treatment room in response to comments as you would expect, that that was unduly burdensome for smaller facilities. CMS actually dialed back this requirement and said no just needs to be readily available somewhere within the hospital as appropriate to the level of services and the volume of services provided regarding staff training. And again, this will be effective on January 1, 2027.

This will sound very familiar to the structure of those staffing training in the emergency for emergency services. Again, the governing body must identify and document the staff required to complete both initial training and then bi annual training on evidence based best practices and protocols, as well as those issues identified through your Quality Assurance and Performance Improvement Program. Note here, as compared to the proposed rule, CMS now is specific. Calling out in this COP initial training, so one that you have a new hire, or an individual that's been transferred into a role where they would be part of the OB services that they need to receive a certain they need to be completing certain training. And then they had proposed annual training, they backed that down now to biannual training on these policies and procedures. Again, this idea that the governing body can delegate the task, but they remain responsible. Again, the requirement that you must be able to articulate their standards and the sources to demonstrate that their staff training requirements are, in fact, based on evidence based best practices. And again, they need to use those findings to their floppy program to inform their staff training needs.

Now this kind of presents an interesting question. I assume we're going to see sub regulatory guidance in this area, but as I noted previously, evidence-based practice is always evolving, always improving, and we want to encourage hospitals to follow and adopt those latest evidence based practices, but we only have a requirement to train every two years. I would not equate the two that yes, you should be continually updating your practices based on what your copy program is telling you what you're seeing in evidence-based practice, and then as appropriate training staff as you make those changes. But that may not necessarily check the box on your biannual training, but certainly for those new adopted practices to be effective, you're going to have to marry that to some training degree. Again. You have to document successful completion of the training and staff personnel records, and you must be able to demonstrate the staff actually learn something during the training through some sort of staff demonstration of staff knowledge. So there is a lot there to be implemented, luckily, over the next two, next two years, ramping up to the compliance date.

Finally, we've referenced this previously several times, but the changes to the Quality Assurance and Performance Improvement COPs to now specifically call out OB services within the QAPI program. So there is an expectation now that OB program leadership must be engaging in Quality Assurance and Performance Improvement Activities to assess and improve health outcomes as well as address disparities among OB patients. And you see here in the bullet points, we won't worry our way through each of those, but the expectation of what these QAPI activities improve specifically call out that OB leadership must be performing at least one measurable OB focus Performance Improvement Project each year. CMS does note in the final rule that some of these performance improvement projects may last over several years. In response to comments saying, Does that mean I have to initiate a new program every year? But no, actually carrying one program, one project from year to year is sufficient to satisfy this requirement as well. And again, CMS promises some sub regulatory guidance on how surveyors will assess compliance. Of course, I would be remiss not to note that we are still waiting for that sub regulatory guidance regarding the conditions of participation for critical access hospitals around QAPI that were effective sometime during the pandemic, either in 2020 or 2021, we finally received the hospital updated interpretive guidelines with respect to changes that were made in about the same time periods the QAPI COPs, but we're still waiting for that sub regulatory guidance for critical Access Hospitals.

You knew I couldn't resist, Kathy, on that.

Kathy Reep 48:42

On that. I do. I knew it was coming.

Martie Ross 48:45

So understandably, this is the kind of the big bombshell, if you can say such a thing about a final rule published by CMS. But this is certainly one change. It's going to be very impactful a very short period of time for hospitals and one for which we need to be devoting resources. It is. It's interesting. As you read through CMS responses to comments that there's several where they will note, the commenter will say, it's burdensome, it's too short, too much work, and CMS just very lightly and sometimes not so lightly, reminds the folks of the maternal health crisis we're facing, and in fact, is there not too much that can't be done to try and address these particular issues. So on that Kathy, that closes out our discussion of this year's 2025 issue, 2025 OPPS Final Rule. Let's switch gears a bit and talk about the Medicare patient status appeals Final Rule.

Kathy Reep 49:44

Just a little bit about the final rule here. More information will be coming to you piecemeal between now and the first part of next year, but we have talked in previous webinars about the proposed rule. Related to patient status appeals, and the fact that this was an issue that went back to when we really started being aggressively using outpatient observation services, and the fact that the courts had decided that patients did not have appeal rights under the existing regulations, like they do from a discharge perspective on inpatient so let's go to the next slide and look at exactly which patients we are talking about.

First of all, traditional Medicare only. This is not Medicare Advantage, so only focus on those who are Medicare fee for service, traditional Medicare, Original Medicare, however you might want to call it, but traditional Medicare beneficiaries, only two groups of patients, first of all, those beneficiaries who were initially admitted as an inpatient reclassified to outpatient observation, but they do not have Medicare Part B. And then secondly, those hospitals, those patients who were originally admitted as inpatient, reclassified to observation, they had at least three days within the hospital setting, but they did not have three days as an inpatient. Therefore, if we were looking to discharge those patients to skilled nursing, they did not have a three-day qualifying stay. If more than 30 days have passed since the discharge from the hospital and the SNF admission, then you don't have to look at worry about that three-day qualifying stay, but this is those patients who were in the hospital at least three days, but they did not have three days as an inpatient to qualify them for skilled nursing.

The court case that we referenced was Alexander the Azar. This was in Connecticut. It was originally filed in 2011 so we are going backwards in time. So now that we have a final decision in the rule, let's talk about what we have to do beginning and the most recent thing we have seen from CMS on. This is the first part of this will be providing a new Medicare change of status notification in CSN to patients who are originally inpatient, change to outpatient observation. This is going to be given to the patient while they are still in the hospital, it informs them of their appeal rights. Let me just share with you what the form says. First of all, you're getting this notice because your hospital changed your status from hospital inpatient to hospital outpatient, receiving observation services the hospital changed. Secondly, there are two boxes for you to check. One is, while you're still in the hospital, your hospital stay will now be billed

to part B instead of part A. Your hospital bill may be lower or higher than the Part A inpatient deductible, and your hospital can give you more information about billing. And finally, after you leave the hospital, Medicare will not pay if you go to a skilled nursing facility. Thus those are going to be the patients who didn't have that three day qualifying stay. Second group of patients. While you're still in the hospital, the hospital may charge you the full cost of your outpatient hospital stay because you don't have Medicare Part B after you leave the hospital, Medicare will not pay if you go to a skilled nursing facility. So recognize these are the two boxes that you are checking off on the MCSN, and you are expected to provide this to the patient as soon as possible after their status changed, but at least four hours prior to discharge, you have given them the NCSN, which addresses their appeal rights, and they then have the opportunity to appeal that determination to move them from inpatient to outpatient.

CMS has now posted the MCSN. I've given you the link on the slides. It is currently available in about five languages, of which English is one, so really four additional languages. Hopefully we will get more than that. But you do have the actual form. It is a very simple form, but I go back to the statement The hospital has changed your status, that I think becomes issue number one. So let's talk about the patient's appeal rights.

So, some things that of note, these are finalized in this the CPT book and Valerie was so nice to point out that this is going to be confusing, or could be confusing, because commercial players are going to be using these new adopted codes where CMS is not so this is something of note.

Martie Ross **54:50**

Kathy had a question, so what? What's the difference between the moon and the MCSN, please, because I know I don't, I don't, I…go ahead.

Kathy Reep **55:00**

Okay, the moon. The Medicare outpatient observation notice is given to all patients who go into outpatient observation. The MCSN is given to those patients who convert from in to out. Now, the question is, do I give them both? CMS has not said yet. Why not, though, right? Yeah, here, while I'm giving you that piece of paper, let me give you another one. Suddenly paper, but we have essentially three types of appeals.

We're going to focus on the first two. These are your prospective appeals, and there are two types of prospective appeals. The first is expedited appeal, which means that before the patient actually even leaves the hospital, they are going to reach out to the QIO to appeal the conversion of their stay from inpatient to outpatient. Now they don't have to stay in the hospital during the time period that that appeal is being determined by the QIO, but they can. The QIO under these expedited appeals, will make a determination of patient status within one calendar day of the request for a review. If it is determined that the decision to convert from inpatient to outpatient was correct, then it's very likely that the beneficiary will be responsible for co-insurance and deductible for any covered services and the full cost of non-covered services. So this becomes an issue for patients in terms of out of pocket liability for that conversion to an outpatient when they don't have Medicare. Part B.

Second type of appeal that you have from a prospective basis is standard appeals. And this is essentially the patient is going to go home. You've given them this notice, and they're going to think about it, because

on the bottom of the form, it says, after you leave the hospital, you still have appeal rights. And at that point, on the second page of the form, it talks to them about who the QIO is, how to reach out to the QIO, how to submit an appeal. And so they will have the opportunity after the fact to appeal their status. And at that point, the QIO has a little bit longer, more like two calendar days to make a determination, but it is not that one calendar day of review.

Now, those are the two types of appeals that you we will see going forward, but we've got this other little headache out there, and these are retrospective appeals. These retrospective appeals are going to go back to any status changes affecting those two types of patients, going back to January 1, 2009 I vote. We're going to see a lot of ads after we're through with open enrollment. From entities telling patients of their appeal rights, and if you think your status was changed from inpatient to outpatient, you're responsible for the bill, or you did not get into skilled nursing because you didn't have a qualifying stay, then those patients will have to follow the normal appeals process, which is starting with a request to the Medicare Administrative Contractor, going to the quick the administrative law judge, Medicare appeals, counsel, federal court, etc. But this becomes this opportunity for the patients to appeal their status, going backwards if the court, if the decision is well, I guess before that, beneficiaries will have 365 days from the actual implementation of this rule, January one for prospective appeals, most likely Happy Valentine's Day, but February 14 or 15th, for retrospective appeals, they will have 365 calendar days from the rule implementation to file an appeal again, going back to January 1, 2009

As a provider, you will have 120 days to submit record requests. Once you get a request to submit records, once you get a request from the contractor, interesting little provision in this rule, because it says that providers will not be penalized if you're unable to locate the records. In other words, record retention. You know, if we're looking at going back to 2009 by the time we start looking at this and 2025 we're looking at 15 years of records. If you can't locate the records because of record retention, etc., we didn't have Electronic Health Records in 2009, you are not going to be penalized. I don't think that says in the rule you're not going the patient isn't going to be successful in their appeal if you can't produce records, it merely means that your failure to produce records will not result in a penalty on your hospital, per se. If there is a decision in favor of the patient, then you will have 365 days to submit a new claim. Excuse me, but if you did receive any part B pay payments again, this is probably going to be that patient going into skilled nursing who had Part B, you're going to have to refund Part B payments, and if you fail to do that, the Mac is going to recoup those payments anyway. We're going to be getting new billing guidelines, because we're going to have to put certain condition codes, Mark codes on our claims on the next slide.

This is just the most recent information that we have related to the effective date. Retrospective appeals operational by January one, 2025 prospective February 15. So recognize, you're going to start January one giving the form, but then the appeals start after that, Martie.

Martie Ross 1:01:21

Too much fun. Well, we hope to see you again, because we're going to start our deep dive into the Medicare Physician Fee Schedule next Wednesday, the 20th, then two more additional webinars after the Thanksgiving holiday. December, for December 11 information for enrolling for these two, three courses is available on our website.

Otherwise, Kathy and I promise probably sometimes in January, we're thinking we're going to do a webinar on a yet to be determined omnibus bill, right? Because there's just a few things Congress needs to wrap up before the end of the year. Deep Dive in those provisions sometimes in early January.

Stay tuned for that! Otherwise, Jennifer, back to you to close this out.

PYA Moderator 1:02:09

All right, thanks to our presenters, Martie Ross and Kathy reap later today, you'll receive an email with their contact information and a recording of this webinar, also the slides and recordings for every episode of PYA is healthcare regulatory roundup series are available on the Insights page of PYA is website, pyapc.com while at our website, you may register for other PYA webinars and learn more about the full range of services offered by PYA.

Please remember to stay on the line once the webinar disconnects, to complete a short survey and to post any other questions you may have.

On behalf of PYA, thank you for joining us and have a great rest of your day!