Illinois Health and Hospital Association

RULE SUMMARY

AUGUST 2024

MEDICARE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Overview

In July, the Centers for Medicare & Medicaid Services (CMS) released the proposed calendar year (CY) 2025 payment rule for the Medicare Outpatient Prospective Payment System (OPPS). The proposed rule includes annual updates to Medicare fee-for-service (FFS) outpatient payment rates as well as regulations that implement new policies. CMS estimates a $5.2 billion increase in OPPS payments for CY 2025 over CY 2024. The proposed rule also includes policies that would:

- Add three services to the Inpatient Only (IPO) list;
- Update the core based statistical areas (CBSAs) used in determining a hospital's wage index;
- Add two new status indicators representing separately payable, non-opioid post-surgical pain management products;
- Change the Obstetrical Services Conditions of Participation (CoPs);
- Update the requirements for the Hospital Outpatient Quality Reporting (OQR) Program;
- Update the requirements for the Rural Emergency Hospital Quality Reporting (REHQR) Program; and
- Update payment rates and policies for Ambulatory Surgical Centers (ASCs).

The proposed rule and other resources related to the OPPS are available on the CMS website. An online version of the CY 2025 OPPS proposed rule is also available here. Comments are due to CMS by Sept. 9, 2024 and can be submitted electronically at http://www.regulations.gov by using the website's search feature for "CMS-1809–P".

OPPS Payment Rate

CMS is proposing to use CY 2023 claims data and CY 2022 Healthcare Cost Report Information System (HCRIS) data for CY 2025 OPPS rate setting. The tables below show the final CY 2024 conversion factor compared to proposed CY 2025 conversion factor and the components of the CY 2025 update factor:

	Final CY 2024	Proposed CY 2025	Percent Change
OPPS Conversion Factor	$87.382	$89.379	+2.29%

Proposed CY 2025 Update Factor Component	Change to OPPS Conversion Factor
Market Basket (MB) Update	+3.0%
Affordable Care Act (ACA)-Mandated MB Productivity Adjustment	–0.4 percentage points (PPT)
Wage Index Budget Neutrality (BN) Adjustment	+0.26%
Wage Index 5% Stop Loss BN	-0.18%
Pass–through Spending / Outlier BN Adjustment	-0.45%
Cancer Hospital BN Adjustment	+0.06%
Overall Proposed Rate Update	**+2.29%**

Adjustments to the Outpatient Rate and Payments

Wage Index: For CY 2025 OPPS payments, CMS is proposing to 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 proposes to 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 hospitals. This continuation would be in effect for at least three more years, beginning in FFY 2025, so that the policy would be in effect for at least four full fiscal years after the end of the COVID-19 PHE. CMS proposes to continue to offset these wage index increases in a budget neutral manner by applying a budget neutrality adjustment to the national standardized amount.

CMS notes that this policy is subject to pending litigation (*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 additional briefing on an appropriate remedy. This court decision involves only FFY 2020, is not final, and has been appealed by CMS.

CMS also applies a 5% cap on any decrease of the hospital wage index, 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 CY.

CMS is proposing a wage index and labor-related share budget neutrality factor of 1.0026 for CY 2025 to ensure that aggregate payments made under the OPPS are not greater or less than would otherwise be made if wage index adjustments had not changed. CMS is also proposing a separate budget neutrality factor of 0.9982 for the impact of the 5% cap on wage index decreases.

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

For CY 2025, in order to align with IPPS, CMS is also proposing to update the CBSA delineations used for the application of the wage index under OPPS. The next section of this brief details CMS' proposals regarding this from the FFY 2025 IPPS Proposed 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 proposing to adopt the newest OMB delineations for the FFY 2025 IPPS wage index.

If CMS adopts this proposal, 54 counties and 33 hospitals that are currently part of an urban CBSA would be considered located in a rural area (including one urban county in Connecticut being redesignated to a newly proposed rural CBSA), listed in the table on *FFY 2025 IPPS PR* pages 36143 – 36144.

Adopting this proposal would also cause 54 counties and 24 hospitals that are currently located in rural areas to be considered located in urban areas, listed in the table on *FFY 2025 IPPS PR* pages 36145 – 36146. Due to these revisions, some critical access hospitals (CAH) previously located in rural areas may now be located in urban areas. Affected CAHs would have a two-year transition period that begins from the date the redesignation becomes effective and must reclassify as rural during this transition period in order to retain their CAH status after the transition ends. Also, special statuses limited to hospitals in

rural areas may be terminated unless the hospital is granted a rural reclassification prior to October 1, 2024.

Lastly, adopting these delineations would cause some urban counties to shift between new or existing urban CBSAs. In some cases, this would change the name or numbers of certain CBSAs. This detail can be found in the tables on *FFY 2025 IPPS PR* pages 36147 – 36150.

CMS is also proposing that for counties that are removed from a CBSA and become rural, a hospital that is reclassified to that CBSA with a current "home area" reclassification would receive the wage index applicable to other hospitals that reclassify into that CBSA, rather than the geographic wage index. CMS notes that this wage index may be lower than the wage index calculated for hospitals geographically located in that CBSA due to hold harmless provisions.

In the case where a proposed CBSA would add or lose a current rural county, a hospital with a current reclassification to the resulting CBSA would be maintained. CMS proposes to maintain Medicare Geographic Classification Review Board (MGCRB) "home area" reclassifications that would reclassify a hospital to one of these counties. Additionally, if a county is proposed to be removed from a CBSA and become rural, then a hospital in that county with a "home area" reclassification would no longer be geographically located in the CBSA to which they are reclassified. Thus, CMS proposes that these reclassifications would no longer be "home area" reclassifications. The table on *FFY 2025 IPPS PR* page 36167 shows the six hospitals for which CMS proposes to terminate reclassifications.

For hospitals which reclassify to CBSAs where one or more counties move to a new or different urban CBSA, CMS proposes that these hospitals would continue to be reclassified to each of their geographic "home area". These could differ from previous years, with affected providers listed in the table on *FFY 2025 IPPS PR* page 36168.

For a hospital that would receive a reclassification that could not continue to their reconfigured CBSA (not including "home area" reclassifications), CMS is proposing to assign the hospital to another CBSA under the revised delineations that contains at least one county from their previous reclassified CBSA and is generally consistent with rules that govern geographic reclassification. Table X on *FFY 2025 IPPS PR* page 36169 lists the eligible CBSAs that hospitals in CBSAs in the situation above could instead reclassify to. Table Y on *FFY 2025 IPPS PR* pages 36170 – 36171 shows all providers subject to this proposed policy. CMS is proposing similar policies to account for reclassifications that will be affected by the proposal to use Connecticut planning regions rather than counties, which can be found on *FFY 2025 IPPS PR* pages 36171 – 36173.

Hospitals in the case described above that wish to be reassigned to a different eligible CBSA, to which the applicable proximity criteria are met, may request reassignment within 45 days of the display date of this rule. This request must be sent to wageindex@cms.hhs.gov and include documentation establishing that they meet the proximity requirements for reassignment to an alternate CBSA that contains one or more counties from the CBSA to which they are currently classified. For hospitals that wish to withdraw or terminate their MGCRB reclassification, CMS is proposing that that providers would have to submit these requests within 45 days of the display date of this rule or within seven calendar days of receiving a decision from the MGCRB on their classification status, whichever is later.

Since CMS already applies a 5% cap on wage index loses from year to year, CMS does not believe any additional transition policies are needed to account for the changes in wage index.

Payment Increase for Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACH): CMS is proposing to 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 is proposing to 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 proposed CY 2025 outlier fixed–dollar threshold of $8,000. This is a 3.2% increase compared to the current threshold of $7,750. Outlier payments are proposed to 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.

Payment for 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 is proposing to 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 the full OPPS payment rate.

For all other excepted off-campus PBDs, CMS is proposing to 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

As required by the CAA of 2023, CMS adopted payment and program requirements for intensive outpatient program services beginning CY 2024. Intensive outpatient services are furnished under a distinct and organized outpatient program of psychiatric services for individuals who have an acute mental illness, called an IOP. IOP services are less intensive than PHP services and can be furnished by a hospital to its outpatients, a CMHC, a federally qualified health center (FQHC), or a rural health clinic (RHC). The final CY 2024 and proposed CY 2025 PHP and IOP payment rates can be found in Addendum A of the proposed rule.

CMS is proposing to 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 expand the calculation of the CMHC outlier percentage to include PHP and IOP.

Inpatient–Only List

CMS is proposing to add the following services to the IPO list, beginning CY 2025:

- 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); and
- 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 proposed to be included on the IPO list is available in Addendum E of the proposed rule.

Proposed HOPD Payment for Telemedicine Evaluation and Management 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 proposes not to recognize the telemedicine E/M code set under OPPS. However, as these services do utilize hospital resources, CMS is also seeking comment on any associated resource costs that would not otherwise be included in hospital payment for HCPCS code G0463.

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

In the CY 2025 PFS proposed rule, CMS proposed an extension of the availability of virtual direct supervision of therapeutic and diagnostic services under the PFS through December 31, 2025. In order to maintain alignment between the PFS and OPPS, CMS is also proposing an extension to virtual direct supervision under the OPPS through December 31, 2025.

Coverage Changes for Colorectal Cancer (CRC) Screening Services

Currently, the following tests and procedures for early detection of colorectal cancer are covered by Medicare: screening fecal-occult blood tests; screening flexible sigmoidoscopies; screening colonoscopies, including anesthesia furnished in conjunction with the service; screening barium enemas; and other tests or procedures established by a national coverage determination, and modifications to tests under this paragraph, with such frequency and payment limits as CMS determines appropriate, in consultation with appropriate organizations.

For CY 2025, CMS is proposing 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); and
- Reassign CPT code 74263 (screening computed tomography colonography (CTC)/virtual coloscopy) to APC 5522 (Level 2 Imaging Without Contrast).

Request for Comment on Payment Adjustments under the IPPS and OPPS for Domestic Personal Protective Equipment (PPE)

Currently, payment adjustments are available to offset the marginal costs faced by hospitals in acquiring domestically made surgical N95 respirators in order to assure that hospitals make use of higher quality respirators instead of less expensive, potentially poorly produced foreign ones. CMS is seeking comment regarding a variety of related topics, including, but not limited to:

- Changes to the payment adjustment methodology;
- Changes to payment adjustment eligibility;
- The types of N95 respirators covered;
- The potential inclusion of nitrile gloves in the payment adjustment; and
- The potential inclusion of other forms of PPE and Medical Devices.

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

On July 12, 2023, CMS proposed to cover PrEP to prevent HIV under Medicare Part B. 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 National Coverage Determination (NCD) has yet to be issued since the release of this proposal. The proposed HCPCS codes for these services may be found in Table 72.

For CY 2025, CMS is proposing to pay for HIV PrEP drugs and services as additional preventive services under OPPS, if covered in the final NCD. Services listed in Table 72 that are furnished in HOPDs are proposed to 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 proposed invoice pricing or the ASP/WAC methodology. If ASP data is unavailable, then CMS proposes to determine the payment amount using the most recently published value in the Medicaid National Average Drug Acquisition Cost (NADAC) survey, or the Federal Supply Schedule (FSS) if NADAC data is unavailable. In the case of drugs that are newly FDA-approved for HIV PrEP, CMS is proposing to require 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 would then be priced at 95% of the drug or biological's AWP.

Finally, CMS is also proposing that, if covered as an additional preventive service, all HCPCS codes describing pharmacy supplying fees for 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); Not paid under OPPS).

Cross-Program Proposal for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs

Advancing Health Equity Using Quality Measures: CMS is committed to advancing health equity and improving health outcomes through quality reporting programs. In support of that commitment, CMS is proposing additional measures for use with the OQR, REHQR and 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)	-
	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 proposing, beginning CY 2025, to modify the immediate measure removal policies for these programs so that they may be more appropriately referred to as immediate measure suspension policies.

Updates to the OQR Program

The OQR program is mandated by law; hospitals that do not successfully participate are subject to a 2.0 percentage point reduction to the OPPS market basket update for the applicable year.

CMS is proposing the addition of three new health equity measures, listed in the section above, and one outcome-based measure to the OQR program:

- 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 proposing 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.

With regard to the three health equity measures being proposed for inclusion, CMS is proposing that HOPDs would 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 HQR System during the period of January 1 through May 15 in the year prior to that measure's use in payment determination.

For Information Transfer PRO-PM, CMS is proposing that HOPDs would be required to submit all required data for the calculation of each measure annually during the period of January 1 through May 15 in the

year prior to that measure's use in payment determination. CMS also proposes to require that HOPDs offer all patients meeting the denominator specifications the opportunity to complete the survey, with a proposed minimum random sample size of 300 completed surveys used to ensure the reliability of the measure. HOPDs unable to collect 300 completed surveys would instead be required to submit data on survey responses from all completed surveys received.

Table 90 lists the 18 measures proposed to be collected for CY 2027 payment determinations, and Table 91 lists the 19 measures to be collected for CY 2031 payment determination.

Beginning with the CY 2025 reporting period, CMS is proposing to require that electronic health record (EHR) technology be certified to all eCQMs available for reporting, and that HOPDs would 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 proposing to make data for the Psychiatric/Mental Health Patients stratification available on Care Compare, beginning CY 2025.

Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process

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

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

Organization, Staffing, and Delivery of Services: CMS is proposing to require new CoPs that if a hospital or CAH offers OB services outside of an 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 is proposing 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 labor and delivery room. CMS is further proposing that the service has readily available supplies and equipment 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. CMS also seeks comment on if these proposed requirements should be applicable to REHs.

Training for OB Staff in Hospitals and CAHs: Given the prevalence of health and safety concerns around maternal health outcomes, CMS is proposing a core set of requirements for facilities offering OB services in order to protect the health and safety of patients. CMS is thus proposing that hospitals and CAHs with OB services be required to develop policies and procedures to ensure that relevant OB services staff would be trained on select topics for improving maternal care delivery. These training topics would need to reflect the scope and complexity of services offered, including best practices and protocols to improve

maternal care delivery. CMS further proposes 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 annual trainings, and staff personnel records must contain information as to if the training was completed successfully, including the demonstration of staff knowledge. CMS seeks public comment in if these requirements should be applicable to REHs, as well as to *"whether CMS should require specific training on person-centered care, trauma-informed care, cultural competency, and/or other topics as part of the evidence-based training."*

QAPI Program: CMS is proposing 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 would mean that a facility, at minimum, would 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 proposing to require that these hospitals' leadership (facility, OB services, or their designees) must be engaged in the facility's QAPI activities.

Emergency Services Readiness: CMS is proposing that hospitals and CAHs that offer emergency services would 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) would 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 proposing 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. Additionally, CMS is seeking public comment on the following:

- While REHs do have existing equipment, supply, and medication standards, should the above proposals related to provisions, protocols, and staff training apply to REHs as well?
- What would be the benefits versus burden of such an approach? How could any burdens be mitigated?

Transfer Protocols: CMS is proposing to require that hospitals have written policies and procedures for transferring patients under their care. This would include transfers within the four walls of the hospital, as well as between different hospitals. CMS is also proposing that hospitals provide training to the appropriate staff regarding patient transfer policies and procedures. In addition, CMS is seeking comment on the following questions:

- How often should staff be trained in transfer protocols?

- What definitions or criteria exist to determine if a transfer is carried out 'promptly and without undue delay'?
- Should hospitals be required to have written policies and procedures outlining their standards and conditions for accepting transfers?
- Should all hospitals (inclusive of CAHs and REHs) be required to have a documented partnership with another hospital that provides OB services, as well as has a Medical Fetal Medicine (MFM) specialist available for consultations in urgent situations, if such service(s) are already offered directly by the hospital? What would be the benefits versus burden of such a policy? How could any burden be mitigated?

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% would not have met the reporting thresholds for the core clinical data elements (CCDEs) and linking variables, and so would have received a 25% reduction to their annual payment update for the given fiscal year had reporting been mandatory.

Due to this information, CMS is proposing that the submission of CCDEs and linking variables remain voluntary for the FFY 2026 payment determination, with mandatory submission being established for the FFY 2027 payment determination.

Request for Information – Overall Hospital Quality Star Rating Modification to Emphasize the Safety of Care Measure Group

CMS is seeking public input on methodologic modifications regarding the Safety of Care measure group within the Overall Hospital Quality Star Rating. An analysis done by CMS has shown a strong relationship between the Safety of Care measure group and the Star Rating, however a provider can still obtain a 5-star rating even if the Safety of Care measure group score is in the bottom quartile. CMS seeks feedback on whether hospitals that fall into this scenario should continue to be eligible to receive a 5-star rating using one of the following methods:

- Reweighting the Safety of Care measure group so that it contributes to more to the Star Rating;
- A policy-based 1-star reduction for providers in the lowest quartile of Safety of Care; or
- A combination of the above approaches.

Specifically, CMS requests comment of the following:

- Do you support re-weighting the Overall Hospital Quality Star Rating measure groups to give greater weight to Safety of Care as described in option 1? Do you agree with the potential new weights for each measure group…?
- Do you support reducing the Star Rating for hospitals with a low Safety of Care score as described in option 2? Do you agree with the potential policy to apply a 1-star reduction to all hospitals in the lowest quartile of Safety of Care?
- Do you support a combination of reweighting the Safety of Care measure group with a 4-star maximum on Star Rating as described in option 3?
- Do you have feedback or preference towards an approach of both up-scoring high performers and down-scoring poor performers as in options 1 and 3, or an approach of just down-scoring poor performers as in option 2?

- What are other methodological approaches that could be used to emphasize the Safety of Care measure group?
- With respect to the potential changes to the Overall Hospital Quality Star Rating methodology, are there any special considerations for small, rural or safety net hospitals (including Critical Access hospitals)?

Contact:
Laura Torres, Manager, Health Policy & Finance
630-276-5472 | ltorres@team-iha.org