Obstetrics (OB), Emergency Readiness and Transfer Conditions of Participation (CoPs) Resource Document 2025 Outpatient Prospective Payment Systems Final Rule

Overview

This resource document was created using the language found in OPPS Final Rule that was finalized November 27, 2024. The new CoPs apply to Hospitals (PPS and others) as covered in the Code of Federal Regulations by 42 CFR Part 482 and to Critical Access Hospitals (CAHs) by 42 CFR Part 485. Context was added to the specific provisions based on the Center for Medicare/Medicaid Services (CMS) response to comments but are not Interpretive Guidelines. This document will be updated when CMS Interpretive Guidelines are released.

In the Final Rule where the new CoPs only reference Hospitals and appear to exclude CAH's, the assumption of the CMS is that a CoP already exists for CAH's covering that requirement. Rural Emergency Hospitals (REHs) are not included in these new CoPs although it is recognized that they already have CoPs in 42 CFR Part 485 Subpart E around equipment, supplies, blood and medications for care of emergency patients (at §485.516(c)(2)) and related to the transfer of patients (at §485.538). It is also recommended that ER readiness for the care of pregnant, birthing and post-partum patients be incorporated, even if specific provisions are not required per this Final Rule.

Timeline

The final regulations were effective 60 days following publication of the Final Rule in the Federal Register. However, CMS chose to stagger the implementation timeframes for the individual CoPs as follows:

Regulatory Section(s)	Implementation Date
Emergency Services Readiness for Hospitals (§482.55) and CAHs (§485.618) *Transfer Protocols for Hospitals (§482.43)*	July 1, 2025
Organization, Staffing and Delivery of Services for Hospitals (§482.59(a) and (b)) and CAHs (§485.649(a) and (b))	January 1, 2026
Training for OB Staff in Hospitals (§482.59(c)) and CAHs (§485.649(c)) *QAPI Program for OB Services in Hospitals (§482.21) and CAHs (§485.641)*	January 1, 2027

Emergency Services Readiness for Hospitals and CAHs (§§ 482.55 and 485.618) (July 1, 2025)

- Maintain protocols consistent with nationally recognized evidence-based guidelines for patients with emergency conditions and to meet the emergency needs of patients in accordance with the complexity and scope of services offered.
    - This includes caring for patients with obstetrical emergencies, complications and immediate post-delivery care but not limited to these conditions.
    - Applies to all hospitals and CAHs providing emergency services, regardless of whether or not the facility offers specific specialty services such as OB.
    - CMS expects that facilities would be able to articulate their standards and source(s) for the protocols and guidelines being followed.
    - CMS doesn't expect facilities to have a protocol or have provisions for every possible emergency scenario but to the extent possible based on 1) the complexity and scope of services offered by the facility and 2) nationally recognized and evidence-based guidelines.
    - Examples given for possible standards: American College of Emergency Physicians, AIM | Alliance For Innovation On Maternal Health, The American College of Obstetricians and Gynecologists, and the Emergency Medical Services for Children Innovation & Improvement Center.
    - EMTALA statute (42 U.S.C. 1395dd) and resulting regulations (42 CFR 489.24) specifies screening and, if emergency medical condition exists, stabilizing treatment and possible transfer. These new CoPs go beyond that to improve readiness and the care provided.

- Facilities must set aside provisions for emergencies, including equipment, supplies, and medications used in treating emergency cases. CMS does not list specific items, but available provisions must include:
    - Drugs, blood and blood products, and biologicals commonly used in lifesaving procedures.
    - Equipment and supplies that are commonly used in lifesaving procedures.
    - Call-in system (call button, bell, alarm, etc.) for each patient in each emergency services' treatment area.
    - These requirements already exist for CAHs at § 485.618(b) and (c), for REHs at § 485.516(c)(2) as well as for Hospital surgical services CoP supply requirements at § 482.51(b)(3).

- Train staff annually on protocols and provisions.
    - Governing body must identify and document appropriate staff to be trained.
    - Training must be informed by QAPI program findings per §§482.21 and 485.641 and that best align with the facility's specific situation.
    - Must be able to document successful completion of training in staff personnel records.
    - Must be able to demonstrate staff knowledge on training topics.

Transfer Protocols for Hospitals (§482.43) (July 1, 2025)

- Must have written policies and procedures for transferring the facility's patients to the appropriate level of care as needed to meet the patient's needs.
    - Not limited to OB patients
    - Including intra-hospital transfers of hospital inpatients as well as transfers to other facilities.
    - The purpose is to ensure that patients are transferred to the appropriate level of care promptly, without undue delay, to protect the health and safety of all patients.
    - This applies even to hospitals without emergency departments or otherwise not covered by EMTALA.
    - CAHs are to meet this per previous CoPs §§485.642(b) and 485.616(a) and REHs per §485.538 with regards to transfer and discharge arrangements and requirements.

- Must provide annual training to the relevant staff regarding the hospital's policies and procedures for transferring patients under its care.
    - CAHs are to provide annual training for ER readiness per §485.618(e)(2) so would recommend following that timeframe.

Organization, Staffing and Delivery of OB Services Outside of an ED (§§ 482.59 and 485.649) (January 1, 2026)

- OB services must be well organized and provided in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients.
    - The source of the acceptable standards is not dictated by CMS in the Final Rule but be expected to cite the source of the standards being followed when surveyed.
    - Examples given for possible standards: The American College of Obstetricians and Gynecologists and the Society of Fetal Medicine, along with other HHS, CMS and HRSA resources available.
    - Until Interpretive Guidance is developed, CMS recommends looking at interpretive guidance in the State Operations Manual (SOM Appendix A for PPS and SOM - Appendix W for CAHs) for surgical services or similar services, for description of "well organized".

- The organization of the OB services must be appropriate to the scope of services offered by the facility and be integrated with other departments in the facility.
    - Specific integration requirements for OB services are §§ 482.59(a) and 485.649(a).
    - No standards for staffing levels provided, as both Hospitals and CAHs are required to provide nursing care to meet patient needs per §§ 482.23(b) and (c) and 485.635(d).

- OB patient care units must be supervised by an individual with the necessary education and training, such as an experienced RN, certified nurse midwife, APP, or physician

- Includes labor rooms, delivery rooms, including rooms for operative delivery and post-partum/recovery rooms, whether combined or separate.

- OB privileges must be granted subject to written criteria for all practitioners providing OB care in accordance with the current requirements for hospitals and CAHs and per the facility medical staff bylaws.
  - Existing CoPs allow for the privileging and credentialing of practitioners other than physicians, including nurse midwives (§ 482.12(a) and (c); § 482.22).
  - No additional CoPs for practitioner staffing beyond previously existing CoPs.

- Hospitals and CAHs must have basic equipment for treating OB cases at the facility and be readily available for treating OB cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered by the facility.
  - At the very least, the equipment needed includes a call-in system (call button), cardiac monitor, and fetal doppler or monitor.
  - It is up to hospitals to determine how to stock equipment in a manner that aligns with the facility's scope, volume, and complexity of OB services offered (that is, per facility, per unit, or per room).

- Hospitals and CAHs must ensure they have adequate provisions and protocols consistent with nationally recognized and evidence-based guidelines for OB emergencies, complications, immediate post-delivery care, and other patient health and safety events.
  - Specific items – beyond what is listed above - are stated as possible examples but should be determined based on the guidelines used and as identified though the facility QAPI program to care for their obstetrical and neonate populations.
  - Examples of provisions include equipment, supplies, medications and blood used in treating emergency cases and can be maintained in OB emergency carts/bags/kits, etc. to be readily available.
  - Facilities that do not provide inpatient OB care but provide outpatient prenatal, maternity, and/or postpartum care, remain subject to all applicable existing hospital and CAH CoPs. Example – Hospital CoP for Outpatient Services (§ 482.54)

Training for OB Staff in Hospitals and CAHs (§§ 482.59(c) and 485.649(c)) (January 1, 2027)

- Hospitals and CAHs must develop policies and procedures to ensure that relevant staff are trained on certain topics aimed at improving the delivery of maternal care.
  - Training topics must reflect the scope and complexity of services offered, including, but not limited to, facility-identified, evidence-based, best practices and protocols to improve the delivery of maternal care within the facility.
  - CMS suggests utilizing support from Quality Improvement Organizations (QIOs), Perinatal quality collaboratives (Ex. Kansas Perinatal Quality Collaborative) and/or use of the AIM | Alliance For Innovation On Maternal Health for assistance.

- Hospitals and CAHs must use findings from their QAPI programs as required in §§ 482.21 and 485.641 to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis.
    - Continuously study and improve processes and service delivery, with a proactive approach per QSO-23-09-Hospital.

- The governing body of the hospital must identify and document which staff must complete initial training and subsequent biannual training (every 2 years). Hospitals and CAHs must also document in staff personnel records that training was successfully completed and be able to demonstrate staff knowledge on the training topics identified.
    - Similar to the governing body appointing the person to oversee infection prevention, CMS believes they can delegate tasks and responsibilities while still maintaining overall responsibility for compliance.

QAPI Program for OB in Hospitals and CAHs (§§ 482.21 and 485.641) (January 1, 2027)

- OB leadership must engage in OB QAPI activities to assess and improve health outcomes and disparities among OB patients on an ongoing basis.
    - Leadership is defined as facility leadership, obstetrical services leadership, or their designate(s).
    - Analyze data and quality indicators by diverse subpopulations that best fits their patient population and resources.
    - Measure, analyze, and track health equity 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 identified outcomes and disparities, develop and implement actions to improve outcomes and disparities, and track performance to ensure improvements are sustained when disparities exist among obstetrical patients.
    - Conduct at least one measurable OB-focused PI project annually focused on improving health outcomes and disparities among the hospital's population(s) of obstetrical patients annually. The project can be repeated each year, if indicated.
    - Builds on CMS quality initiatives like "Birthing-Friendly" designation, and work by State Perinatal Quality Collaboratives (Kansas Perinatal Quality Collaborative). A facility can also partner with a QIO.
    - Data from KPQC, CMS IQR maternal health quality measures, or other Federal or State maternal health quality initiatives can be used to reduce the burden.

- Include process for incorporating Kansas Maternal Mortality Review Committee data and information into the QAPI program.

References: OPPS Final Rule, pages 1,392 – 1,483 and 1,725 – 1,734; eCFR :: 42 CFR Chapter IV Subchapter G Part 482 and Part 485; QSO-23-09-Hospital;

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