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CY 2024 Outpatient Prospective Payment System and Ambulatory Surgery Center Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) recently issued the Calendar Year (CY) 2024 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule. Despite a proposed rate increase, industry groups remain concerned that the increase does not keep pace with rising costs in today's inflationary environment. In addition to the rate change, the proposed rule also includes revisions to hospital price transparency requirements and expands access to behavioral health services. This article includes a recap of key provisions.

KEY TAKEAWAYS

- *Proposed rate increase of 2.8% for OPPS and ASC (before quality reporting penalties or sequestration)*
- *No procedures will be removed from the Inpatient Only list*
- *Primary additions to ASC Covered Procedures list are dental services*
- *Expanded coverage for mental health services*
- *340B drugs to be paid at ASP + 6% in 2024*
- *Proposed remedy for 2018 – 2022 340B underpayments includes lump sum payment, with 0.5% reduction in OPPS rates starting in 2025 to achieve budget neutrality*
- *Enhanced price transparency requirements and enforcement*

Payment Rate

Most notably, the proposed rule includes an increase of 2.8% for both the OPPS and ASC payment rates. This rate is based on a market basket increase of 3%, reduced by 0.2 percentage point as a result of the productivity adjustment. The payment rate will be reduced by 2% for hospitals and ASCs that fail to comply with applicable outpatient quality reporting (OQR) requirements. Accordingly, the proposed **OPPS conversion factor for 2024 is $87.488** (or $85.782 for hospitals that fail to meet OQR requirements), and the proposed **ASC conversion factor is $53.397** (or $51.854 for ASCs that do not meet the quality reporting requirements). CMS estimates that the rate increases and other budget neutrality adjustments will result in an aggregate payment increase of $6 billion from 2023 OPPS payments, and an increase of $220 million from 2023 ASC payments.

As a result of the OPPS rate increase and other budget neutrality adjustments, CMS estimates that urban hospitals will see an increase in payments of around 2.8% while rural hospitals will experience a 4.4% increase. Nonteaching hospitals are expected to yield a 3.5% increase, while minor teaching hospitals and major teaching hospitals are anticipated to experience 3% and 2.4% increases, respectively.

CMS estimates that surgical specialties will experience varying levels of payment fluctuations as a result of the ASC provisions in the final rule, ranging from a 6% decrease for nervous system procedures to a 7% increase for GI services. The anticipated decrease in payments for nervous system procedures relates primarily to an expected shift in utilization from an existing high-cost neurostimulator procedure (CPT code 64685) to a new procedure with a lower cost (CPT code 0X43T). Other specialties are expected to see increases based on the combined effect of the higher conversion factor, new technologies, and changes in payment policy. Policy changes include the creation of an additional Intraocular Procedures level, resulting in a six-level structure, which impacts the expected increase in overall payments for the eye specialty.

Surgical Specialty	Estimated Payment Change
Gastrointestinal	7%
Genitourinary	6%
Eye	6%
Cardiovascular	4%
Musculoskeletal	3%
Nervous System	(6%)

Derived from Table 101 in the CY 2024 Medicare Hospital OPPS and ASC Payment System Proposed Rule.

Sequestration Impact

It should be noted that the payment rates reflected in the OPPS/ASC final rule are prior to any reduction for sequestration. A 2% Medicare sequestration cut stems from a 2011 law that required across-the-board spending cuts for the federal government from fiscal year (FY) 2013 to FY 2030. Under this law, Medicare cuts cannot exceed 2%. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share. Subsequent legislation suspended the application of sequestration to Medicare to provide relief to providers during the COVID-19 pandemic; however, the full 2% sequestration will be in force for 2024.

In addition to sequestration, the Statutory Pay-As-You Go Act (PAYGO) enacted in 2010 requires spending cuts across the federal government if legislation enacted in a year results in an increase in projected budget deficits. The omnibus bill passed by Congress at the end of 2022 postpones these spending cuts until at least 2025. Without that bill, all Medicare payments would be subject to an additional 4% cut. While this means 2024 pay rates will not be impacted by PAYGO, the pay cut would apply in 2025 without further legislative intervention.

Changes to IPO & ASC Covered Procedures Lists

CMS is not proposing to remove any services from the Inpatient Only (IPO) list for 2024. However, nine services for which codes were newly created for 2024 are proposed to be added to the IPO list since it was determined that they require a hospital inpatient admission or stay. One additional code (0646T) that is currently designated as not payable by Medicare is proposed to be added to the IPO list as a covered service.

The Proposed Rule also seeks to add 26 dental surgical procedures to the ASC Covered Procedures List as it was determined that they may all be appropriately performed in an ASC setting without posing a significant safety risk to the patient. However, Medicare payment may only be made in the ASC setting for dental services that qualify for payment under Medicare Part B under the Outpatient Prospective Payment System (OPPS) *and* that meet the ASC covered procedures criteria. Generally, dental services are covered under the OPPS only when they are inextricably linked to certain Medicare-covered services or treatments.

Mental Health Services

Partial Hospitalization and Intensive Outpatient Programs

In light of heightened awareness of the need for mental health services, the Consolidated Appropriations Act, 2023 (CAA 2023) included provisions that expand the definition of partial hospitalization services and adds coverage of intensive outpatient services beginning in 2024. CMS describes a partial hospitalization program (PHP) as an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for patients with acute mental illness, including substance use disorders. A PHP may be provided by a hospital or a community mental health center (CMHC) as a distinct and organized intensive ambulatory treatment service, with less than 24-hour daily care, in a location other than the patient's home or an inpatient or residential setting. The legislation requires a physician to determine that each PHP patient requires a minimum of 20 hours of services each week, with redetermination occurring at least monthly. The Proposed Rule implements that requirement.

The Proposed Rule also establishes an intensive outpatient program (IOP), as required by CAA 2023. An IOP is similar to a PHP but has a lower threshold – a minimum of 9 hours per week – for which a physician determines that a patient needs psychiatric services. IOP services may be provided by a hospital, a CMHC, a federally qualified health center (FQHC), or a rural health clinic (RHC) as a distinct and organized intensive ambulatory treatment service, with less than 24-hour daily care, in a location other than the patient's home or an inpatient or residential setting. A physician must redetermine the need for IOP services at least every other month. Covered IOP services include the following:

- Individual or group therapy with physicians, psychologists, or other mental health professionals;
- Occupational therapy;
- Services of social workers, psychiatric nurses, and staff with appropriate training;
- Therapeutic drugs
- Individual activity therapies;
- Family counseling focused on the patient's care and treatment;
- Diagnostic services; and
- Other reasonable and necessary services (excluding meals and transportation) for the diagnosis or treatment of the patient's condition.

Notably, the following services are separately covered and therefore will not be paid as part of an IOP, consistent with existing exclusions from PHP:

- Physician services;
- Physician assistant services;
- Nurse practitioner and clinical nurse specialist services;
- Qualified psychologist services; and
- Services furnished to residents of a skilled nursing facility (SNF).

The Proposed Rule adopts all but one of the HCPCS codes currently applicable for PHP services, adds 18 additional codes currently recognized as mental health codes under the OPPS, and updates five existing codes recognized for PHP to also refer to IOP. To qualify for payment under the IOP ambulatory payment classification (APC), at least one service must be from the PHP and IOC Primary Services List. The proposal includes separate per diem amounts for IOP and PHP services provided by hospitals or CMHCs. The rates

are based on either 3 services per day, or 4 or more services per day. The law requires payment rates to be site-neutral for services furnished by hospital outpatient departments, FQHCs, and RHCs. Therefore, CMS has proposed separate rates for services furnished by hospitals and by CMHCs, as shown below:

		3 Services per Day		4+ services per day	
		APC	Payment Rate	APC	Payment Rate
PHP	CMHC	5853	$ 97.59	5854	$ 153.09
	Hospital	5863	$ 284.00	5864	$ 368.18
IOP	CMHC	5851	$ 97.59	5852	$ 153.09
	Hospital	5861	$ 284.00	5862	$ 368.18

However, CMS is also considering a site-neutral payment for all providers of IOP services. The proposed rule includes this alternative, with a contemplated PHP and IOP rate of $281.48 for 3 services per day and a rate of $316.63 for 4 or more services per day.

Opioid Treatment Programs

To address the ongoing opioid crisis, CMS seeks to increase access to quality treatment programs and reduce barriers to care. Accordingly, the Proposed Rule establishes payment under Medicare Part B for IOP services furnished by opioid treatment programs (OTPs) for the treatment of opioid use disorder (OUD) beginning in 2024. In order to qualify for OTP IOPs, a physician must certify that the patient needs a minimum of 9 hours per week and requires a higher level of care intensity as compared to existing OTP services. Recertification would be required at least every other month. Certain medications would be excluded from OTP IOP services, as they are already included as part of a bundled payment for an episode of care. This includes medications commonly used for emergency treatment of an overdose.

CMS is proposing a weekly payment adjustment via an add-on code for OTP IOP services to allow greater flexibility in how services may be distributed across a given week. In order to bill the add-on code, the OTP IOP services must be medically necessary and not duplicative of any services for which a bundled payment is already available for an episode of care. The add-on code, GOTP1, has a proposed payment rate of $719.67, which would be adjusted annually based on the percentage increase in the Medicare Economic Index (MEI). Consistent with existing policy that applies to other OUD treatment services, there would be no beneficiary copayment for OTP IOP services.

340B Drug Program

CMS proposes to maintain its policy adopted in 2023 to pay the statutory default rates for drugs and biologicals acquired through the 340B program, which allows participating hospitals to acquire drugs at discounted prices. Generally, this rate reflects the average sales price (ASP) plus 6%.

Proposed Rule to Remedy for the 340B-Acquired Drug Payment Policy

In 2018, CMS changed its methodology for determining payments for outpatient drugs acquired through the 340B program. The change in methodology resulted in a significant decrease in payments to hospitals. As a result, the program has been the subject of extensive litigation. On June 15, 2022, the Supreme Court ruled that the payment rates paid by CMS in 2018 and 2019 were inappropriate, as the Department of Health and Human Services (HHS) did not have the authority to vary payment rates among groups of hospitals without a survey of the hospitals' acquisition costs. A survey was not conducted until 2020. Accordingly, CMS must determine how to make hospitals whole for the pay cuts they experienced in 2018 and 2019, which were around $1.6 billion annually in aggregate.[1]

On July 7, 2023, CMS issued a separate proposed rule addressing the proposed remedy for the inappropriate

[1] *American Hospital Assn.* v. *Becerra,* 596 U. S. ___ (2022)

payments from 2018 through 2022. This proposal calls for CMS to make lump-sum payments, totaling around $9 billion, to each of the approximately 1,600 hospitals that was impacted by the inappropriate payments. Such payments are intended to account for beneficiary cost sharing; accordingly, hospitals may not bill beneficiaries for coinsurance on the lump-sum payments. Importantly, the proposed rule also declares that the remedy requires budget neutrality. To accomplish this, **CMS proposes to reduce future payments for non-drug items and services by reducing the OPPS conversion factor by 0.5% starting in 2025** and continuing until the full $7.8 billion budget neutrality adjustment is offset, which is expected to take 16 years. Any hospitals that were not enrolled in Medicare until after January 1, 2018, would not be subject to the conversion factor reduction in future years.

Price Transparency

In the Proposed Rule, CMS seeks to enhance compliance with the hospital price transparency rules that currently exist. Proposed changes include the following new requirements:

- Affirmation by hospitals of the accuracy and completeness of the standard charges reflected in the machine-readable files;
- Inclusion of additional data elements in the posted files;
- Use of a CMS template to create consistency by reporting hospitals; and
- Adoption of new requirements to improve automated accessibility of the posted files.

Additionally, the Proposed Rule contains provisions to enhance enforcement of the price transparency requirements. These include:

- Giving CMS the express authority to conduct a comprehensive compliance review of a hospital's standard charge information posted on a publicly available website;
- Requiring an authorized hospital official to certify the accuracy and completeness of the posted information at any state of the monitoring, assessment, or compliance phase;
- Requiring submission to CMS of additional documentation, as requested;
- Requiring hospitals to acknowledge receipt of any warning notices issued by CMS;
- Allowing CMS to notify health system leadership of any action taken against a hospital within that system; and
- Allowing CMS to publicize on its website information relating to its assessment of a hospital's compliance, any compliance action taken, and the status and outcome of any compliance action.

Other Provisions

Quality Reporting Programs

As previously noted, the Proposed Rule reflects a 2% reduction in the OPPS and ASC payment rates for failure to meet quality reporting requirements. Additionally, CMS proposes to modify the reporting requirements by revising certain existing measures and also adding new ones. Changes include the following, which would be reflected in both the Outpatient Quality Reporting Program (OQRP) and the ASC Quality Reporting Program:

- Update the COVID-19 Vaccination Coverage Among Healthcare Personnel measure to utilize the term "up to date" in the vaccination definition.
- Limit the survey instruments that can be utilized to assess changes in visual function for the Cataracts Visual Function Measure.
- Modify the Colonoscopy Follow-Up Interval to reflect the updated clinical recommendation that people of average risk begin screening at age 45 rather than age 50.

Additional measures are proposed for the OQRP that would have voluntary reporting periods beginning in 2025 and mandatory reporting periods in subsequent years. These include volume data for selected outpatient surgical procedures, outcome-based measures following total hip or knee replacements, and measures relating to excessive radiation or inadequate image quality for CT services.

Remote Behavioral Health Services

Current rules allow remote behavioral health services provided by clinical staff of hospital outpatient departments to Medicare patients in their homes to be considered as covered services payable under the OPPS. The Proposed Rule extends the waiver of the requirement that each patient receive an in-person service within six months prior to the initiation of the remote service and every 12 months thereafter until January 1, 2025. Additionally, CMS proposes to allow payment for outpatient therapy (including physical therapy, occupational therapy, and speech-language pathology services), diabetes self-management training, and medical nutrition therapy furnished via telehealth by qualified providers on the staff of hospital outpatient departments through the end of 2024.

Dental Services

The Proposed Rule seeks to assign 229 additional dental codes to APCs for OPPS payment in 2024. Payment for these services would only be permitted when they fall within the qualifying scope of service (i.e., inextricably linked to certain covered treatments or services).

What's Next?

Industry groups are continuing to apply pressure to both CMS and Congress, maintaining that the payment rates combined with mandated sequestration cuts will result in insufficient funding to support operations and will inhibit Medicare beneficiaries' access to care. Comments relating to the Proposed Rule may be submitted until September 11, 2023, with a final rule expected in early November.

While applauding CMS's proposal to provide lump-sum payments to hospitals as a remedy for the unlawful cuts to the 340B Drug Pricing Program, advocacy groups for the hospital industry have expressed disappointment that the proposed remedy is budget-neutral. Additionally, there is frustration that the payments, intended to address underpayments from as far back as 2018, will not include interest. The comment period for the 340B remedy proposed rule will end on September 5, 2023, with a final rule expected in advance of the OPPS/ASC Payment System final rule.

JTaylor's healthcare consulting team includes experienced professionals who focus on strategy and operations for all types of providers. If you are interested in finding out how the CY 2024 OPPS/ASC Proposed Rule may impact reimbursement for your facility, we can help. Our team can also support you from a strategic perspective as you determine how to respond to the upcoming changes in Medicare reimbursement. To find out more or to contact a member of our team, please visit our website.

Resources:

- Fact Sheet: CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS 1786-P)
- Proposed Rule: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction
- Fact Sheet: Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Proposed Rule (CMS 1793-P)
- Proposed Rule: Medicare Program; Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022