JTaylor™

Healthcare Consulting | Valuation

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

On November 2, The Centers for Medicare and Medicaid Services (CMS) issued the *Calendar Year (CY) 2024 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System* final rule. Despite a higher rate increase than originally proposed, industry groups remain concerned that it is still insufficient to keep pace with rising costs. In addition to the rate change, the rule also adopts the proposed revisions to hospital price transparency requirements and expands access to behavioral health services. Separately, CMS on the same day issued another final rule: *Hospital OPPS: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022.* This article includes a recap of key provisions from both rules.

KEY TAKEAWAYS

- *Rate increase of 3.1% for OPPS and ASC (before quality reporting penalties or sequestration), which is higher than the 2.8% increase that had been proposed.*
- *No procedures will be removed from the Inpatient Only list.*
- *Addition of several procedures to the ASC Covered Procedures list, including total shoulder arthroplasty.*
- *Expanded coverage for mental health services.*
- *340B drugs to be paid at ASP + 6% in 2024.*
- *Lump-sum payment to remedy for 2018 – 2022 340B underpayments, with 0.5% reduction in OPPS rates starting in 2026 to achieve budget neutrality.*
- *Enhanced price transparency requirements and enforcement*

Payment Rate

Most notably, the final rule increases both the OPPS and ASC payment rates by 3.1%, which is an improvement over the 2.8% increase reflected in the proposed rule. This rate is based on a market basket increase of 3.3%, reduced by 0.2 percentage point for the productivity adjustment. CMS acknowledged concerns raised in public comments that the proposed rate increase was inadequate, but noted that there is a statutory requirement for the outpatient department fee schedule increase factor to equal the inpatient payment system (IPPS) market basket percentage increase factor. Accordingly, the final rule adopted the 3.3% market basket increase that was reflected in the IPPS final rule issued by CMS in August.

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 **OPPS conversion factor for 2024 is $87.382** (or $85.687 for hospitals that fail to meet OQR requirements), and the **ASC conversion factor is $53.413** (or $52.476 for ASCs that do not meet the quality reporting requirements). CMS estimates that total payments to OPPS providers (inclusive of beneficiary cost-sharing and estimated changes in enrollment, utilization, and case mix) will increase by approximately $6 billion over CY 2023, while ASC payments are expected to increase by $207 million.

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 3.2% while rural hospitals will experience a 4.2% increase. Nonteaching hospitals are expected to yield a 3.9% increase, while minor teaching hospitals and major teaching hospitals are anticipated to experience 3.5% 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 an 11% decrease for nervous system procedures to an 8% 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 63685) to a new procedure with a lower cost (CPT code 64596). 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	9%
Genitourinary	8%
Eye	8%
Cardiovascular	4%
Musculoskeletal	1%
Nervous System	(11%)

Derived from Table 169 in the CY 2024 Medicare Hospital OPPS and ASC Payment System Final 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 and continue through FY 2032.

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. To date, the PAYGO sequestration has never been triggered, and the Consolidated Appropriations Act, 2023 postpones these spending cuts until at least 2026. However, PAYGO sequestration, including a 4% reduction to Medicare payments, could be triggered in early 2026 unless legislative action is taken before then. However, neither the Budget Control Act nor the Statutory PAYGO Act include explicit directions as to how the two sequesters would be implemented together.

Changes to IPO & ASC Covered Procedures Lists

No services will be removed from the Inpatient Only (IPO) list for 2024. However, nine services for which codes were newly created for 2024 were added to the IPO list, as proposed, 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 was added to the IPO list as a covered service.

The ASC Covered Procedures list will see the addition of 37 procedures in 2024, including the 26 dental procedures that had been proposed and 11 additional procedures evaluated during the public comment period. The additional procedures include shoulder arthroplasty, ankle arthroplasty, and knee arthroscopy with medial or lateral meniscal transplantation, which CMS determined can be safely performed in an ASC setting based on support and evidence provided by commenters. While CMS determined that the 26 dental services may all be appropriately performed in an ASC setting without posing a significant safety risk to the patient, Medicare payment may only be made for dental services that qualify for payment under Medicare Part B under the 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 final rule implements that requirement.

The final 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 authorized mental health professionals;
- Occupational therapy;
- Services of social workers, psychiatric nurses, and other staff with appropriate training;
- Therapeutic drugs;
- Individual activity therapies;
- Family counseling focused on the patient’s care and treatment;
- Patient training and education 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 final rule adopts all but one of the HCPCS codes currently applicable for PHP services, adds a number of additional codes currently recognized as mental health codes under the OPPS, updates five existing codes recognized for PHP to also refer to IOP, and removes one code that was determined to not be widely used in the provision of PHP. 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 rule includes separate per diem amounts for IOP and PHP services provided by hospitals or CMHCs. The rates are based on either three or fewer services per day, or four 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 adopted 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
PHP	Hospital	5863	$ 284.00	5864	$ 368.18
IOP	CMHC	5851	$ 97.59	5852	$ 153.09
IOP	Hospital	5861	$ 284.00	5862	$ 368.18

In the proposed rule, CMS noted it was also considering a site-neutral payment for all providers of IOP services. However, the final rule did not adopt site-neutral payment rates.

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 final 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 nine 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 will 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 adopting 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, GO137, will have a payment rate of $778.20, geographically adjusted using the Geographic Adjustment Factor (GAF). This payment rate will 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

The OPPS/ASC final rule maintains the 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%. Accordingly, drugs and biologicals acquired under the 340B program will be paid at the same rate as those not acquired under 340B.

Currently, 340B hospitals report either “JG” or “TB” modifiers to identify drugs and biologicals acquired through the 340B program. CMS believes that transitioning to a single code will allow for greater simplicity and reduce the burden on providers. Accordingly, all 340B covered entity hospitals will be required to report a “TB” modifier for 340B-acquired drugs and biologicals starting January 1, 2025. Hospitals that currently report the “JG” modifier may choose to either continue using it in 2024 or transition to the “TB” modifier prior to the 2025 effective date.

Remedy for the 340B-Acquired Drug Payment Policy for 2018-2022

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 make hospitals whole for the pay cuts they experienced in 2018 and 2019, which were around $1.6 billion annually in aggregate.

The final rule relating to the 340B program remedy adopted the approach reflected in the proposed rule issued in July. Under this policy, CMS will make lump-sum payments, totaling around $9 billion, to each of the approximately 1,700 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, CMS maintains its position that the remedy has a statutory requirement for budget neutrality. To accomplish this, **CMS will reduce future payments for non-drug items and services by reducing the OPPS conversion factor by 0.5% starting in 2026** and continuing until the full $7.8 billion budget neutrality adjustment is offset, which is expected to take 16 years. The reduction was originally proposed to start in 2025, but was delayed in response to public comments that hospitals need additional time to plan for the decreased reimbursement. 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 final rule, CMS affirms its position that the release of hospital standard charge information, on its own, is insufficient to achieve the goals of price transparency for driving competition in the marketplace or allowing consumers to compare prices and make informed decisions. While CMS believes the benefits of the enhancements to the price transparency regulations outweigh the burden on hospitals, it is adopting a phased implementation timeline in response to public comments. The effective date of the changes to hospital price transparency regulations is January 1, 2024. However, enforcement of certain provisions will not begin until later, as noted below.

The enhanced requirements include the following:

- Affirmation by hospitals of the accuracy and completeness of the standard charges reflected in the machine-readable files (required beginning July 1, 2024);
- Inclusion of additional data elements in the posted files (required beginning July 1, 2024);
- Use of a CMS template to create consistency by reporting hospitals (required beginning July 1, 2024);
- Adoption of new requirements to improve automated accessibility of the posted files; and
- Acknowledgement by hospitals of warning notices and publication of more information about CMS enforcement activities related to individual hospital compliance.

Additionally, the final 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 final rule reflects a 2% reduction in the OPPS and ASC payment rates for failure to meet quality reporting requirements. Additionally, CMS modified 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 in the OQRP will have voluntary reporting periods beginning in 2025 and mandatory reporting periods in subsequent years. These include outcome-based measures following total hip or knee replacements and measures relating to excessive radiation or inadequate image quality for CT services. CMS did not finalize its proposal regarding reporting of volume data for selected outpatient surgical procedures.

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. As proposed, the final 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 twelve months thereafter until January 1, 2025. Additionally, CMS will 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 final rule assigns 243 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?

Response to the final rule by industry groups has been mixed. While the American Hospital Association (AHA) expressed concern over what it described as an "inadequate update" to hospital payments, the Ambulatory Surgery Center Association (ASCA) had a more positive response. The ASCA was particularly pleased with the addition to the ASC Covered Procedures List of certain procedures that had not been included in the proposed rule – specifically, total shoulder arthroplasty. Further, ASCA applauded the extension of the linkage of the ASC update factor with the one used to update hospital outpatient payments through 2025, a position it had advocated for.

The 340B remedy also drew a mixed response. Generally, hospitals were appreciative of the lump-sum payment to reimburse for prior year underpayments. However, the hospital industry characterized the budget neutrality "clawback" in future years as a "grievous mistake" that was made by CMS after receiving "hundreds of comments from hospitals and other providers explaining why this Medicare cut is both illegal and unwise." It is possible this provision will lead to another round of litigation, as hospitals maintain that they should not be subjected to underpayments in future years as a result of CMS implementing an unlawful payment methodology in prior years.

JTaylor's healthcare consulting team includes experienced professionals who focus on valuation, strategy, and operations for all types of providers. If you are interested in finding out how the CY 2024 OPPS/ASC final 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:

- CMS Resources:
  - Fact Sheet: *CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1786-FC)* (November 2, 2023.)
  - Fact Sheet: *Hospital Price Transparency Fact Sheet.* (November 2, 2023.)
  - Final Rule: *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Hospital Outpatient Departments, Community Mental Health Centers, Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction.* (November 2, 2023.)
  - Fact Sheet: *Hospital Outpatient Prospective Payment System (OPPS): Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule* (CMS 1793-F). (November 2, 2023.)
  - Final Rule: *Medicare Program; Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022.* (November 2, 2023.)
- American Hospital Association. (November 2, 2023.) *AHA Statement on CY 2024 OPPS Final Rule.* https://www.aha.org/press-releases/2023-11-02-aha-statement-cy-2024-opps-final-rule
- American Hospital Association. (November 2, 2023.) *AHA Statement on Final 340B Remedy*. https://www.aha.org/press-releases/2023-11-02-aha-statement-final-340b-remedy
- Ambulatory Surgery Center Association. (November 2, 2023.) *CMS Releases 2024 Final Payment Rule.* https://www.ascassociation.org/asca/news-and-publications/news/2023/cms-releases-2024-final-payment-rule-2023-11-01