Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

AUGUST 2023

CY24 MEDICARE OPPS PROPOSED RULE – CMS-1786-P

On July 31, the Centers for Medicare & Medicaid Services (CMS) published its calendar year 2024 (CY24) outpatient prospective payment system (OPPS) proposed rule. Overall, CMS proposed a rate update of 2.8% relative to CY23, estimating an increase of $6 billion compared to CY23 OPPS payments.

Within this rule, CMS proposed creating standardized formats for hospital price transparency files; expanded access to behavioral health services; paying for 340B acquired drugs and biologicals at the average sales price (ASP) plus 6%; and adopting new measures for the various Quality Reporting Programs. CMS is also seeking comments on possible revisions to the inpatient-only (IPO) list.

An IHA memo summarizing CMS' CY24 340B payment remedy is *here*.

OPPS Rate Update: CMS proposed a 3% market basket update and a 0.2 percentage point productivity reduction for OPPS payments, resulting in a 2.8% update to OPPS rates for hospitals that meet quality data submission requirements. After accounting for all adjustments, CMS proposed a CY24 conversion factor of $87.488. Hospitals that fail to submit quality data will be subject to a 2-percentage point reduction to payments, resulting in a conversion factor of $85.782. CMS used CY22 claims data and the most updated cost report extract available from the Healthcare Cost Report Information System, which primarily includes cost reports with cost reporting periods including CY21.

Proposed 340B Drug Payment Policy: CMS proposed to continue paying for 340B-acquired drugs and biologicals at the ASP plus 6%. This reverses several years of paying for 340B-acquired drugs and biologicals at ASP minus 22.5%.

Wage Index: CMS proposed continuing its policy to use the fiscal year 2024 (FY24) Inpatient Prospective Payment System (IPPS) post-reclassified wage index for outpatient payments. The final CY24 OPPS wage index reflects the IPPS wage index in the FY24 IPPS final rule and can be found *here*. Additionally, CMS proposed to continue to use a labor-related share of 60% for CY24.

Behavioral Health Updates:

Payment for Remote Mental Health Services

In the CY23 OPPS final rule, CMS created three HCPCS C-codes (C7900 – C7902) to describe mental health services furnished by Hospital-Based Outpatient Department (HOPD) staff to beneficiaries in their homes through communications technology. In this rule, the agency proposed to adopt an additional, untimed code describing remote group psychotherapy. In addition, the agency proposed other technical refinements to how these codes are recorded that would allow for multiple units to be billed on the same day. Finally, CMS would delay the

requirements for an in-person visit within six months prior to the first remote mental health service and within 12 months after each remote mental health service until Jan. 1, 2025.

Intensive Outpatient Program (IOP) Benefit

CMS proposed establishing programmatic requirements under Medicare for the coverage of IOP services, beginning Jan. 1, 2024. These requirements would govern:

- The scope of benefits and definition of IOP services paid on a per-diem basis;
- Minimum number of hours of IOP services per week (9) and frequency (at least every other month) for IOP coverage eligibility; and
- Payment rates, established as two Ambulatory Payment Classifications (APCs) for each provider type and number of services provided per day.

In addition, CMS would make conforming regulatory text changes to reflect that the newly established IOP requirements would be the same for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) as for hospitals. CMS would also extend IOP coverage to include programs provided by opioid treatment programs (OTPs) and Community Mental Health Centers (CMHCs).

Partial Hospitalization Program (PHP) Updates

CMS proposed updates to the payment rates for Partial Hospitalization Program (PHP) services in HOPDs and CMHCs. The agency would expand the existing rate structure of only one APC for each provider type to include two PHP APCs for each provider type; one for days with three services per day and one for days with four or more services per day. To calculate the hospital-based and CMHC PHP payment rates for three services per day and four or more services per day, the agency proposes to use a broader OPPS dataset that includes both PHP and non-PHP days rather than the current methodology that only uses PHP data. Finally, CMS clarified that Medicare coverage for PHP services includes services rendered for treatment of substance use disorders in addition to mental illnesses.

Proposed CY24 PHP and IOP APC Geometric Mean Per Diem Costs

CY 2024 APC	**Group Title**	**Proposed PHP and IOP APC Geometric Mean Per Diem Costs**
5851	Intensive Outpatient (3 services per day) for CMHCs	$96.49
5852	Intensive Outpatient (4 services per day) for CMHCs	$151.36
5853	Partial Hospitalization (3 services per day) for CMHCs	$96.49
5854	Partial Hospitalization (3 services per day) for CMHCs	$151.36
5861	Intensive Outpatient (3 services per day) for hospital-based IOPs	$280.80
5862	Intensive Outpatient (4 services per day) for hospital-based IOPs	$364.04

5863	Partial Hospitalization (3 services per day) for hospital-based PHPs	$280.80
5864	Partial Hospitalization (4 services per day) for hospital-based PHPs	$364.04

Alternative CY24 PHP and IOP APC Geometric Mean Per Diem Costs

Group Title	Alternative PHP and IOP APC Geometric Mean per Diem Costs
Partial Hospitalization (3 services per day)	$281.48
Partial Hospitalization (4 services per day)	$316.63
Intensive Outpatient (3 services per day)	$281.48
Intensive Outpatient (4 services per day)	$316.63

CMHC Conditions of Participation (CoP)

In addition to the newly added coverage for IOP services described above, CMS also proposed provisions to implement a statutorily required benefit category for services from mental health counselors and marriage and family therapists. This would involve modifying the CoPs for CMHCs. CMS also requested feedback on how these new benefits would impact CMHCs' ability to meet current requirements in their CoPs to provide at least 40% of services to individuals who are not eligible for Medicare Part B.

Supervision by Non-Physicians of Certain Rehabilitation Services: For CY24, to comply with provisions of the Bipartisan Budget Act of 2018 and to ensure consistency with the proposed changes in the CY24 Physician Fee Schedule proposed rule, CMS proposed to expand the practitioners who may supervise cardiac rehabilitation, intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation services. Nurse practitioners, physician assistants and clinical nurse specialists are now included. It also proposed to allow for the direct supervision requirement for these services to include virtual presence of the physician through audio-video, real-time communications technology (excluding audio-only) through Dec. 31, 2024, and, to extend this policy to these non-physician practitioners, who are eligible to supervise these services in CY24.

Inpatient Only List (IPO): For CY24, CMS did not propose removing any services from the IPO list. It solicited comments, however, regarding whether the services described by CPT codes 43775, 43644, 43645 and 44204, gastric restrictive procedures, are appropriate to be removed from the IPO list. Specifically, CMS requested information on evidence as to whether these services can be performed safely on the Medicare population in the outpatient setting. In addition, CMS proposed adding nine services for which codes were newly created by the American Medical Association's Current Procedural Terminology Editorial Panel for CY24 to the IPO list.

Reporting Discarded Single-dose or Single-use Package Drugs: In the CY24 Medicare Physician Fee Schedule (PFS) proposed rule, CMS proposed implementing Section 90004 of the 2021 Infrastructure Act, which requires manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. This impacts both HOPDs and ASCs.

Payment for ICR: CMS proposed to correct an unintended reimbursement disparity caused by the Medicare Improvements for Patients and Providers Act of 2008, to pay for ICR services provided by an off-campus, non-excepted, provider-based department of a hospital at 100% of the OPPS rate for cardiac rehabilitation services, rather than 40% of the OPPS rate.

Price Transparency Proposals: CMS proposed to amend several hospital price transparency requirements to reportedly improve monitoring and enforcement capabilities that reduce the compliance burden on hospitals. See this IHA memo for more details on these proposals.

RFI on Potential Payment Establishing and Maintaining Access to Essential Medicines: CMS is seeking comments on *"separate payment under IPPS for the IPPS share of the reasonable costs of establishing and maintaining access to a 3-month buffer stock of one or more essential medicine(s). Essential medicines for the potential IPPS separate payment would be the 86 essential medicines prioritized in the report Essential Medicines Supply Chain and Manufacturing Resilience Assessment. An adjustment under OPPS could be considered for future years."*

Outlier Payments: To maintain total outlier payments at 1% of total OPPS payments, CMS proposed using CY22 claims to calculate a CY24 outlier fixed–dollar threshold of $8,350. This is a 3.2% decrease compared to the current threshold of $8,625. 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 APC payment amount when both the 1.75 multiplier threshold and the fixed–dollar threshold are met.

Packaged Services: CMS proposed continuing to create more complete APC payment bundles over time in order to package more ancillary services when they occur on a claim with another service, and to only pay for them separately when performed alone.

For CY24, CMS proposed continuing to un-package, and pay separately at ASP plus 6%, the cost of non–opioid pain management drugs that function as surgical supplies when they are furnished in the ASC setting. CMS will not pay separately for these drugs when furnished in the Hospital Outpatient Department (HOPD) setting. These drugs are only eligible if the drug or biological does not have transitional pass-through payment status and the drug must not already be separately payable in the OPPS or ASC payment system.

Table 63 on page 49,767 lists the products that are proposed to continue to have separate payment in the ASC setting under this policy for CY24.

Hospital Outpatient Quality Reporting Program (OQR): CMS proposed removing one measure beginning with the CY24 reporting period/CY26 payment determination:

- Left Without Being Seen.

Additionally, CMS proposed modifying three previously adopted measures beginning with the CY24 reporting period/CY26 payment determination:

- COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure to use the term "up to date" in the HCP vaccination definition and to update the numerator to specify the timeframes within which an HCP is considered up to date with CDC recommended COVID–19 vaccines, including booster doses;

- Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure to allow HOPDs to use the Visual Function Patient Questionnaire (VF-14), the Visual Functioning Index Patient Questionnaire (VF-8R), or the National Eye Institute Visual Function Questionnaire-25 (NEI VFQ-25) survey instruments for administering and calculating the measure; and
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure to update the denominator by replacing the phrase "aged 50 years" with the phrase "aged 45 years."

Lastly, CMS proposed adding three new measures to the OQR program:

- Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures with modification to more granularly collect and publicly display data reported for the top five most frequently performed procedures among HOPDs within each category (voluntary CY 2025 reporting period with mandatory reporting CY 2026 reporting period/CY 2028 payment determination);
- Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO–PM) (voluntary CYs 2025 and 2026 reporting periods with mandatory reporting CY 2027 reporting period/CY 2030 payment determination); and
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults measure (voluntary CY 2025 reporting period with mandatory reporting CY 2026 reporting period/CY 2028 payment determination).

CMS also proposed to publically report measure data for Median Time for Discharged Emergency Department (ED) Patients-Transfer Patients and Median Time for Discharged ED Patients-Overall Rate beginning with CY24.

CMS is seeking comments on the following measurement topics with regard to the Hospital OQR program:

- Promoting safety (patient and workforce);
- Behavioral health; and
- Telehealth.

Table 66, listing the 18 measures to be collected for CY26 payment determinations is on page 49,790. Table 67, listing the 21 measures to be collected for CY27 payment determination is on page 49,791.

ASC Rate Update: CMS proposed extending the policy used in CY19 through CY23, to CY24 and CY25, which updates the ASC payment system using the hospital market basket. As such, it proposed increasing payment rates by 2.8% for ASCs that meet the quality reporting requirements under the ASC Quality Reporting (ASCQR) Program.

ASC Covered Procedures List (CPL): CMS proposed adding 26 dental surgical procedures to the ASC CPL based upon its existing regulatory criteria.

ASC Quality Reporting Program (ASCQR): CMS proposed several of the same updates to the ASCQR as it does for the OQR, including the same modifications to the three existing measures; the adoption of the surgical procedural volume measure; and the adoption of the patient-reported outcomes following total hip and/or total knee arthroplasty measure.

Sources:
Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; etc. Published on July 31, 2023. Available from: https://www.federalregister.gov/documents/2023/07/31/2023-14768/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment. Accessed Aug. 15, 2023.