Illinois Health and Hospital Association

RULE BRIEF

NOVEMBER 2023

CY 2024 Medicare Outpatient Prospective Payment System – Final Rule Brief

Overview

The Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2024 Medicare Outpatient Prospective Payment System (OPPS) final rule on Nov. 2, 2023. CMS estimates a $6.0 billion increase in OPPS payments for CY 2024 over CY 2023.

OPPS Payment Rate

CMS will used CY 2022 claims data and CY 2021 Healthcare Cost Report Information System (HCRIS) data from the December 2022 extract to update the OPPS payment rate.

The table below shows the final CY 2023 conversion factor compared to final CY:

	Final CY 2023	Final CY 2024	Percent Change
OPPS Conversion Factor	$85.585	$87.382 (proposed at $87.488)	2.1% (proposed at 2.22%)

Adjustments to the Outpatient Rate and Payments

Wage Indexes: CMS will continue to use the federal fiscal year (FFY) 2024 inpatient PPS (IPPS) wage indexes, including all reclassifications, add–ons, rural floors, and budget neutrality adjustments.

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 wage index and the 25th percentile wage index value across all hospitals. CMS will continue to offset these increases 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.

In the FFY 2023 IPPS final rule, CMS adopted the application of a 5% cap on any decrease of the FFY 2023 hospital wage index, and all future wage indexes, compared with the previous year's wage index. This same cap is in place for OPPS. The cap is to be applied regardless of the reason for the decrease and implemented in a budget neutral manner nationally.

CMS is adopting a wage index and labor-related share budget neutrality factor of 0.9912 (proposed at 0.9974) for CY 2024 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 adopting a separate budget neutrality factor of 0.9997 (proposed at 0.9975) 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 2024, CMS will continue to use a labor–related share of 60%.

Payment Increase for Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACH): CMS will 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.

Outlier Payments: To maintain total outlier payments at 1% of total OPPS payments, CMS used CY 2022 claims to calculate a CY 2024 outlier fixed–dollar threshold of $7,750 (proposed at $8,350). This is a 10.1% decrease compared to the current threshold of $8,625. Outlier payments will 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.

Updates to the APC Groups and Weights

CMS must review and revise the APC relative payment weights annually. CMS must also revise the APC groups each year to account for drugs and medical devices that no longer qualify for pass–through status, new and deleted Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, advances in technology, new services, and new cost data. The final payment weights and rates for CY 2024 are available in Addenda A and B within Addendum P of the final rule.

Calculation of Cost-to-Charge Ratios (CCRs): For CY 2024, CMS will continue to use the hospital-specific overall ancillary and departmental cost-to-charge ratios to convert charges to estimated costs.

New Comprehensive Ambulatory Payment Classifications (APCs): CMS created two new C-APCs for CY 2024, for a total of 72 C-APCs. A list of the 72 adopted C–APCs for CY 2024 can be found in Table 2.

Universal Low Volume APCs Payment Policy: For CY 2024, CMS will continue the universal low-volume APC payment methodology for services assigned to New Technology, clinical, and brachytherapy APCs with fewer than 100 claims. This policy uses the highest of the geometric mean, arithmetic mean, or median based on up to 4 years of claims data to set the payment rate for the APC.

Payment for Drugs, Biologicals and Radiopharmaceuticals: For CY 2024, CMS adopted a packaging threshold of $135. Drugs, biologicals, and radiopharmaceuticals that are above the $135 threshold are paid separately, using individual APCs, and those below the threshold are packaged; the baseline payment rate for CY 2024 is the ASP + 6%. Separately payable drugs and

biological products that do not have pass–through status are to be paid wholesale acquisition cost (WAC) + 3%, instead of WAC + 6%.

For CY 2024, CMS will continue to pay for blood clotting factors and therapeutic radiopharmaceuticals with pass–through payments status at ASP + 6%. If ASP data are not available, payment instead would be made at WAC + 3%; or 95% of average wholesale price (AWP) if WAC data are also not available.

CMS has concerns that packaging biosimilars when the reference biological or other marketed biosimilar are separately paid may create financial incentives for providers to select more expensive, but clinically similar, products. Therefore, CMS is finalizing that beginning CY 2024, biosimilars would be exempt from the OPPS threshold packaging policy when their reference biologicals are separately paid; CMS would pay separately for these biosimilars even if their per-day cost is below the packaging threshold.

Finally, the pass–through status will expire by Dec. 31, 2023 for the 43 drugs and biologicals listed in Table 89 and by Dec. 31, 2024 for the 25 drugs and biologicals listed in Table 90. CMS will continue/establish pass–through status in CY 2024 for the 59 drugs and biologicals shown in Table 91.

Other OPPS Policies

Partial Hospitalization (PHP) and Intensive Outpatient (IOP) Psychiatric Services: 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).

CMS will allow IOP services to include individual and group therapy; occupational therapy; drugs and biologicals furnished for therapeutic purposes, which cannot be self-administered; family counseling; beneficiary education; and diagnostic services.

CMS will allow CMHCs to be a participating provider of both PHP services and IOP services. CMS is adding 29 HCPCS codes to the current list of codes that are recognized for PHP payments to address IOP services. These codes can be found in Table 98.

Beginning CY 2024, CMS will establish four separate PHP APC per diem payment rates: one for CMHCs for 3-service days and another for CMHCs for 4-services days, and one for hospital-based PHPs for 3-service days and another for hospital-based PHPs for 4-service days. CMS will continue to calculate CMHC payment rates based solely on CMHC claims, in order to recognize differences in cost structures for different PHP providers.

CMS will also establish consistent coding and payment between the PHP and IOP benefits, and therefore, will consider all OPPS data for PHP days and non-PHP days that include 3 services per day and 4 services per day as well as establish four separate IOP APC per diem payment rates at the same rates adopted for PHP APCs.

The table below compares the final CY 2023 and final CY 2024 PHP and IOP payment rates found in Addendum A:

	Final Payment Rate 2023	Final Payment Rate 2024	% Change
APC 5851: Intensive Outpatient (3+ services) for CMHCs	-	$87.66	-
APC 5852: Intensive Outpatient (4+ services) for CMHCs	-	$157.58	-
APC 5853: Partial Hospitalization (3+ services) for CMHCs	$142.70	$87.66	-38.57%
APC 5854: Partial Hospitalization (4+ services) for CMHCs	-	$157.58	-
APC 5861: Intensive Outpatient (3+ services) for Hospital–based IOPs	-	$259.40	-
APC 5862: Intensive Outpatient (4+ services) for Hospital–based IOPs	-	$358.21	-
APC 5863: Partial Hospitalization (3+ services) for Hospital–based PHPs	$268.22	$259.40	-3.29%
APC 5864: Partial Hospitalization (4+ services) for Hospital–based PHPs	-	$358.21	-

CMS will 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.

IOP Services Furnished by RHCs and FQHCs: Beginning CY 2024, services of a marriage and family therapist (MFT) or mental health counselor (MHC) are covered under RHC and FQHC services if the MFT or MHC is employed or under contract with the RHC or FQHC at the time the services are furnished. Also starting CY 2024, IOP services are covered in both RHCs and FQHCs.

The CAA of 2023 also allows for special payment rules for furnishing intensive outpatient services in both FQHCs and RHCs, both equal to the amount that would have been paid under Medicare IOP services had they had been covered outpatient department services furnished by a hospital; that is the payment rates listed in the section above for 3-services per day for RHCs and for FQHCs would be the lesser of a FQHC's actual charges or the 3-services per day payment amount for hospital outpatient departments. Both facility types would be required to report condition code 92 to identify intensive outpatient claims.

Payment for IOP Services Furnished by Opioid Treatment Programs (OTPs): CMS adopted a policy to cover IOP services that are furnished in OTPs and meet the criteria specified, with modification. This policy implements a weekly payment adjustment via an add-on code for IOP services furnished by OTPs for the treatment of opioid use disorder. IOP services provided by OTPs would be paid for as long as each service is medically reasonable and necessary, and not

duplicative of any service paid for under any bundled payments billed for an episode of care in a given week. CMS did not adopt the proposal to deduct the individual and group therapy amounts that are included in the OTP bundled rates. Additionally, CMS is finalizing a change to the definition of OTP IOP services to allow for non-physician practitioners to perform the required certifications.

Inpatient Only (IPO) List: CMS did not remove any services from the IPO list for CY 2024, and added the following ten services:

- CPT 0790T: Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed;
- CPT 22836: Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments;
- CPT 22837: Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments;
- CPT 22838: Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed;
- CPT 61889: Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s);
- CPT 76984: Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic;
- CPT 76987: Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report;
- CPT 76988: Intraoperative epicardial cardiac ultrasound (i.e., echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only
- CPT 76989: Intraoperative epicardial cardiac ultrasound (i.e., echocardiography) for congenital heart disease, diagnostic; interpretation and report only; and
- CPT 0646T: Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, ercutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed.

The full list of measures that will be included on the IPO list is available in Addendum E of the final rule.

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 PBDs, CMS expanded the Medicare Physician

Fee Schedule (MPFS) payment methodology to excepted off–campus PBDs for HCPCS code G0463.

For CY 2024, CMS is adopting that excepted off-campus PBDs of rural SCHs be exempt from the clinic visit payment policy because CMS believes that the volume of the clinic visit service in these hospitals is driven by factors other than the payment differential for the service. These hospitals would continue to bill HCPCS code G0463 with modifier "PO", but CMS would pay these hospitals the full OPPS payment rate.

In addition, CMS will apply the CMHC per-diem rates for hospital PHP and IOP services provided at an off-campus PBD, instead of the MPFS rate for that service.

For all other excepted off-campus PBDs, CMS will continue to pay 40% of the OPPS rate for basic clinic services in CY 2024. These excepted PBDs continue to bill HCPCS code G0463 with modifier "PO".

Lastly, CMS observed that this reduction to non-excepted PBDs for intensive cardiac rehabilitation (ICR) services resulted in an unintended reimbursement disparity between excepted and non-excepted sites of service. Therefore, beginning Jan. 1, 2024, CMS will pay for ICR services provided by an off-campus, non-excepted PBD of a hospital at 100% of the OPPS rate for cardiac rehabilitation services, rather than 40% of the OPPS rate.

Updates to the Hospital Outpatient Quality Reporting (OQR) Program

Hospitals that do not successfully participate are subject to a two percentage point reduction to the OPPS market basket update for the applicable year.

CMS did not remove the Left Without Being Seen measure beginning with the CY 2024 reporting period/CY 2026 payment determination. CMS will modify three previously adopted measures beginning with the CY 2024 reporting period/CY 2026 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 adopted two new measures for addition to the OQR program:

- 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 – 2027 reporting periods with mandatory reporting CY 2028 reporting period/CY 2031 payment determination); and
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults measure (voluntary CYs 2025 and 2026 reporting period with mandatory reporting CY 2027 reporting period/CY 2029 payment determination).

In addition, CMS will 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 CY 2024.

Table 128 lists the 19 measures to be collected for CY 2026 payment determinations. Table 129 lists the 22 measures to be collected for CY 2027 payment determination.

Reporting Discarded Amounts of Certain Single-dose or Single-use Package Drugs

In the CY 2024 Medicare Physician Fee Schedule (PFS) proposed rule, CMS proposed to implement section 90004 of the Nov. 15, 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.

Hospitals can refer to the CY 2024 Medicare PFS final rule for more detail on the adopted changes regarding the date of the initial report to manufacturers and subsequent reports, method of calculating refunds amounts, increased applicable percentages for certain drugs with unique circumstances, a future application processes, and modification to the "JW" and "JZ" modifier policy for drugs payable under Part B from single-dose containers that are furnished by a supplier who is not administering the drug.

Supervision by Nurse Practitioners (NP), Physician Assistants (PA), and Clinical Nurse Specialists (CNS) of Cardiac Rehabilitation (CR), ICR, and Pulmonary Rehabilitation (PR) Services Furnished to Hospital Outpatients

The Bipartisan Budget Act of 2018 required that services provided in a CR, ICR, or PR program can be provided under the supervision of a PA, NP, or CNS beginning Jan. 1, 2024, rather than the current requirement that only physicians could supervise these services as part of the stated programs. In the CY 2024 Medicare PFS final rule, CMS adopted revisions to the regulations in order to match the new requirements.

In the April 6, 2020 "Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency (PHE)" interim final rule with comment period, CMS adopted that during a PHE, for the purposes of direct supervision, a physician can be present virtually through audio/video real-time communications technology for PR, CR, and ICR when the use of technology reduces exposure risks for the patient or the provider. The CAA of 2023 extends this policy through the end of CY 2024. In order to maintain similar policies for OPPS as PFS, CMS proposed to include PR, CR, and ICR with NPs, Pas, and CNSs under the above.

OPPS Payment for Specimen Collection for COVID-19 Tests

In the May 8, 2020 COVID-19 interim final rule with comment period, CMS created a new E/M code, HCPCS code C9803: "Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS–COV–2) (coronavirus disease [COVID–19]), any specimen source, to support COVID-19 testing during the public health emergency." As of May 11, 2023, the PHE ended, and therefore CMS will delete this code, effective Jan. 1, 2024.

Remote Services

In the CY 2023 OPPS final rule, CMS created three HCPCS C-codes (C7900 – C7902) to describe mental health services furnished by hospital staff to beneficiaries in their homes through communications technology. In order to reduce administrative burden and enhance access to these services, CMS is creating a single new untimed, HCPCS C-code describing group therapy:

- C7903: Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service.

CMS also removed the word "initial" from the descriptors of these codes. The final descriptors are listed in Table 109.

In the CY 2023 OPPS final rule, CMS adopted the requirement that a beneficiary receive an in-person visit within 6 months prior to the first time a mental health service is provided remotely, and that there must be an in-person visit within 12 months of each mental health service furnished remotely by the hospital clinical staff. CMS also adopted exceptions to the latter requirement if the hospital clinical staff member and the beneficiary agree that the risks and burdens of an in-person service outweigh the benefits, which must be documented. This in-person 6 month visit requirement did not include beneficiaries who began receiving mental telehealth services in their homes during the PHE or the 151-day period after the end of the PHE before the in-person visit requirements go into effect. CMS is extending the delay in implementation of the in-person visit requirements until Jan. 1, 2025 as set forth by the CAA of 2023.

Separately, the CAA of 2023 also extended additional flexibilities for Medicare telehealth services, including *"retention of physical and occupational therapists and speech-language pathologists as telehealth distant site practitioners, through the end of CY 2024".* In addition, the CY 2024 PFS final rule adopted the continuation of payments for outpatient therapy services, diabetes self-management training, and medical nutrition therapy when furnished via telehealth by qualified employed staff of institutional providers through the end of CY 2024.

OPPS Payment for Dental Services

CMS adopted policies in the CY 2023 PFS final rule to allow for payment for certain dental services performed in outpatient settings. However, there are currently only 57 CDT codes that are assigned to APCs and payable under OPPS for dental services.

In the CY 2023 OPPS final rule, CMS created HCPCS code G0330 to describe facility services for dental rehabilitation procedure(s) furnished to patients who require monitored anesthesia and use of an operating room. This code cannot be used to describe or bill the facility fee for non-covered services. To ensure that dental services can be paid under the OPPS, CMS will assign an additional 243 dental codes to APCs for CY 2024, listed in Table 111.

CMS is finalizing the proposal to package payments for dental services that are performed with another covered dental or medical service. Final APC assignments for these services are available in Addendum B of the final rule.

Hospital Price Transparency

CMS will amend several hospital price transparency requirements to improve monitoring and enforcement capabilities that reduce the compliance burden on hospitals. Specifically, CMS adopted changes in order to:

- Define several items related to the newly adopted policies;
- Revise the standard charge information and data elements that hospitals must include in their machine-readable file (MRF), including the requirement that as of July 1, 2024, each hospital to affirm directly in the MRF that all applicable standard charge information is included and is accurate as of the date of the MRF. Hospitals will also be required to use a template developed by CMS in order to standardize the displayed MRF data files. Beginning Jan. 1, 2024, each hospital must encode, as applicable, all standard charge information corresponding to each required data element in its MRF;
- Improve the standardization of hospital data outputs, including:
    - Enforcement of a 60-day grace period for adoption and conformation to the new CMS template and encoding of standard charge information of the newly proposed data elements;

    - A clarification that required charge information are a component of the required "data elements" of a chart, and not considered data elements themselves, and to what data elements require;
    - For payer-specific negotiated charges the MRF must state whether the standard charge is a dollar amount, or is based on a percentage or algorithm, and to describe the methodology used and to specify the estimated allowed amount; and
    - Additional data element requirements, such as the description of an item or service, and if the service is provided in connection with either an inpatient admission or outpatient visit, as well as the code information (APC, DRG, etc.) associated, along with any code modifiers.
- Improve access to hospital MRFs by requiring hospitals to include a .txt (plain text) file in the root folder of their public website that includes a direct link to the MRF and a link in the footer on its public website labeled "Price Transparency" that links directly to the webpage that hosts the link to the MRF; and
- Improve enforcement processes by updating methods to assess hospital compliance, requiring hospitals to acknowledge receipt of warning notices, working with health system officials to address noncompliance issues in one or more hospitals that are part of a health system, and publicizing more information about CMS enforcement activities related to individual hospital compliance.

CMS provided an implementation timeline of transparency requirements on Tables 151A and 151B.