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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 9, 2023

Key Takeaways

On November 2, the Centers for Medicare & Medicaid Services (CMS) issued the annual final rule to update the Calendar Year (CY) 2024 Medicare payment rates for services payable under the Hospital Outpatient Prospective Payment System (OPPS) (Final Rule). The Final Rule includes changes to payment policies and payment rates at hospital outpatient departments (OPDs) and ambulatory surgical centers (ASCs), in addition to refinements for several quality reporting programs and changes to hospital price transparency requirements. This summary focuses primarily on policies related to hospital OPDs.

Separately, CMS released a final rule (CMS fact sheet and Vizient summary) regarding the remedy for prior, unlawful payment cuts imposed upon 340B hospitals.

Most provisions of the Final Rule will go into effect January 1, 2024.

Major Proposals Finalized & Key Changes from the Proposed Rule

OPPS Payment Update

For CY 2024, CMS finalized policy to apply an outpatient department (OPD) fee schedule increase factor of 3.1 percent, except for those hospitals not meeting certain quality reporting requirements, which would be subject to a 2 percentage point reduction in payments. Notably, the OPD fee schedule increase factor is 0.3 percent higher than proposed because the final inpatient market basket percentage, which is used to determine the OPD fee schedule increase factor, increased from 3.0 percent to 3.3 percent.

CMS estimates that, for CY 2024, the cumulative effect of all finalized changes will increase payments by 3.2 percent for all providers and 3.0 percent for all hospitals, as shown in Table 1.

CMS estimates total payments to OPPS providers for CY 2024 would be approximately $88.9 billion, which is an increase of approximately $6 billion, compared to estimated CY 2023 OPPS payments.

Table 1. Estimated Impact of the Final CY 2024 Changes for the Hospital OPPS

	Number of Hospitals (1)	Proposed Ambulatory Payment Classification Recalibration Changes (2)	New Wage Index and Provider Adjustments (3)**	All budget neutral changes (combined cols 2-3) with Market Basket Update (4)***	All Proposed Changes (5)****
All providers*	3611	0.0	0.1	3.2	3.2
All hospitals	3511	0.1	0.2	3.4	3.3
Urban hospitals	2801	0.1	0.1	3.2	3.2
Rural hospitals	710	0.4	1.4	4.7	4.4
Non-teaching status hospitals	2204	0.4	0.5	4.0	3.9
Minor teaching status hospitals	874	0.3	0.4	3.8	3.5
Major teaching status hospitals	433	-0.5	-0.4	2.2	2.4

* These 3,611 providers include children and cancer hospitals and Community Mental Health Centers.
**Column (3) shows the budget neutral impact of updating the wage index by applying the final FY 2024 hospital inpatient wage index. The final rural Sole Community Hospital (SCH) adjustment would continue the current policy of 7.1 percent, so the budget neutrality factor is 1. The final budget neutrality adjustment for the cancer hospital adjustment is 1.0005 because the final CY 2024 target payment-to-cost ratio (PCR) is less than the CY 2023 PCR target.
***Column (4) shows the impact of all budget neutrality adjustments and the addition of the final 3.1 percent OPD fee schedule update factor (3.3 percent reduced by 0.2 percentage point for the productivity adjustment).
**** Column (5) shows the additional adjustments to the conversion factor resulting from a change in the passthrough estimate and adding estimated outlier payments. Note that previous years included the frontier adjustment in this column, but CMS has moved the frontier adjustment to Column 3 in this table.

Final Updates Affecting OPPS Payments

Payment for Intensive Cardiac Rehabilitation Services (ICR) Provided by an Off-Campus, Non-Excepted Provider Based Department (PBD) of a Hospital

CMS finalized policy to pay for ICR services furnished by off-campus non-excepted PBDs of a hospital at 100 percent of the OPPS rate. Notably, 100 percent of the OPPS is also the amount paid for these services under the Physician Fee Schedule.

340B-Acquired Drugs

For CY 2024, CMS will continue to apply the default rate (e.g., average sales price (ASP) plus 6 percent), to 340B acquired drugs and biologicals. In addition, CMS finalized its proposal to require that all 340B covered entity hospitals paid under the OPPS report a single 340B modifier (the "TB" modifier) effective January 1, 2025. CMS clarifies that the "JG" modifier will remain effective until December 31, 2024, but that hospitals currently reporting this modifier may choose to transition to the "TB" modifier sooner.

Proposed Packaging Threshold

For CY 2024, CMS finalized a packaging threshold of $135, which is $5 less than proposed due to updated data.

Biosimilar Packaging Exception

New, for CY 2024, CMS will except biosimilars from the OPPS threshold packaging policy when their reference products are separately paid (i.e., the reference product's per-day cost falls below the threshold packaging policy).

Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in their Homes

For CY 2024, CMS finalized technical refinements to the existing coding (i.e., HCPCS codes 7900[1], C7901[2] and 7902[3]) for remote mental health services to allow for multiple units to be billed daily. In addition, in the Final Rule, CMS created a new, untimed code to describe group psychotherapy[4] that can be reported when a beneficiary receives multiple hours of group therapy per day.

Since Congress also extended the delay in implementing the in-person visit requirements until January 1, 2025, for both professionals billing for mental health services via Medicare telehealth and for RHCs/FQHCs furnishing remote mental health visits, CMS finalized OPPS policy to align with these changes.

Inpatient Only (IPO) List and Ambulatory Service Center (ASC) Covered Procedure List

For CY 2024, CMS will not remove any services from the IPO list and will add 37 surgical procedures, including total shoulder arthroplasty (HCPCS Code 23472) to the ASC CPL.

Proposed Hospital Outpatient Outlier Payments

OPPS provides outlier payments (added to the Ambulatory Payment Classification (APC) amount) to help mitigate financial risks associated with high-cost and complex procedures that could present a hospital with significant financial loss. For CY 2024, CMS provides a fixed-dollar threshold of $7,750, which is lower than CY 2023's threshold of $8,625, combined with the multiple threshold of 1.75 times the APC payment rate.

Payment for Intensive Outpatient Programs

New for CY 2024 and to implement provisions in the Consolidated Appropriations Act, 2023 (CAA, 2023), CMS established and finalized payment for Intensive Outpatient Program (IOP) services under Medicare and key elements of the IOP benefit, including the scope of benefits, physician certification requirements, and coding and billing. For example, CMS established IOP APC amounts which are based on three services being provided per day or four or more services provided per day. In the Final Rule, the agency indicates IOP services, which are furnished under an IOP, may be provided in hospital OPDs, community mental health centers (CMHCs), federally qualified health centers (FQHCs), and rural health clinics (RHCs). Also, CMS finalized payment for IOP services

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[1] HCPCS Code C7900: Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, 15-29 minutes, 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.
[2] HCPCS Code C7901: Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, 30-60 minutes, 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.
[3] HCPCS Code C7902: Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, 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 (List separately in addition to HCPCS code C9701).
[4] HCPCS C79XX: 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.

provided by opioid treatment programs (OTPs) under the existing OTP benefit. As noted by CMS, IOP services aim to fill the gap between traditional outpatient therapy and partial or full hospitalization for mental health issues.

Partial Hospitalization Program

For CY 2024, CMS finalized changes to the methodology used to calculate CMHC and hospital-based partial hospitalization program (PHP) geometric mean per diem costs. Also, CMS will expand PHP payment from two APCs to four APCs. Unlike IOP services, the PHP is meant to be the most intensive mental health services program as inpatient care would be required if PHP is not received.

Dental Services

For CY 2024, CMS finalized Medicare payment rates under the OPPS for over 240 dental codes. These codes have been assigned to clinical APCs to align with the dental payment provisions in the CY 2024 Physician Fee Schedule final rule.

Hospital Outpatient Quality Reporting Program

CMS finalized several proposals for the Hospital OQR program, including modifications to the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure beginning with the CY 2024 reporting period / CY 2026 payment determinations. This measure has been modified to include the term “up to date” in the HCP vaccination definition and to update the measure to set time frames regarding when HCP is considered up to date with recommended COVID-19 vaccinations. As noted in the Final Rule, the current definition of “up to date” can be found on the CDC’s COVID vaccine website. Also, public reporting of the modified version of the COVID–19 Vaccination Coverage Among HCP measure for the Hospital OQR Program would begin with the Fall 2024 Care Compare refresh, or as soon as technically feasible.

Additionally, with modifications, CMS finalized the proposal to adopt the 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) but provided a one-year delay for mandatory reporting of the measure. As finalized, voluntary reporting would begin with the CY 2025 reporting period through the CY 2027 reporting period and would then become mandatory for the CY 2028 reporting period /CY 2031 payment determination. Similarly, CMS finalized the adoption of the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) measure with voluntary reporting beginning with the CY 2025 reporting period and mandatory reporting beginning with the CY 2027 reporting period/CY 2029 payment determination.

CMS did not finalize the proposal to remove the Left Without Being Seen measure due to data indicating worsening of the measure, or the proposals to re-adopt a modified Hospital Outpatient Volume Data on Selected Outpatient Procedures measure as CMS would like to reassess the measure’s methodology and reconsider how the data may be publicly displayed.

Buffer Inventory Request for Comments

CMS did not finalize policy to provide a payment adjustment to providers maintaining a three-month supply of essential medications due to various stakeholder concerns and a lack of consensus among commenters about a potential Medicare payment policy. CMS notes that while it is not finalizing any change, it intends to propose future policy addressing aspects of hospital practices with respect to pharmaceutical supply, including in future payment rules and through Conditions of Participation.

Updates to Requirements for Hospitals to Make Public a List of their Standard Charges

In the CY 2020 Hospital Price Transparency (HPT) final rule, CMS adopted requirements for hospitals to make public their standard charges in two ways: (1) as a comprehensive machine-readable file (MRF) and (2) in a consumer-friendly format. In the Final Rule, CMS revised several HPT requirements to improve the agency's monitoring and enforcement capabilities, and to improve the usability of hospital standard charge information and to better align display requirements with requirements implemented in the Transparency in Coverage Initiative. The effective date of the Final Rule's changes to the HPT regulations is January 1, 2024. However, more information regarding the implementation timeline is noted below.

Finalized Definitions

CMS finalized regulations to add the following definitions and to make several technical and conforming revisions to ensure the consistency of the use of the new terms in regulation:

- "CMS Template" is a CSV format or JSON schema that CMS makes available for purposes of compliance with the §180.40(a).[5]
- "Consumer-friendly expected allowed amount" means the average dollar amount that the hospital estimates it will be paid by a third-party payer for an item or service.
    - CMS finalized a revised definition to reflect that the amount is based on the average amount the hospital has historically received from the payer, rather than an average amount the hospital expects to receive from the payer.
- "Encode" means converting hospital standard charge information into a machine-readable format that complies with §180.50(c)(2).[6]
- "Estimated allowed amount" is the average dollar amount that the hospital has historically received from a third-party payer for an item or service.
- "Machine-readable file" is a single digital file that is in a machine-readable format.

Requirement that Hospitals Affirm the Accuracy and Completeness of Their Standard Charge Information Displayed in the MRF

CMS notes that since the HPT regulations have been implemented, the public and CMS have questioned the accuracy of the standard charge information hospitals display. As a result of public comments, CMS finalized their proposed policy with a modification. More specifically, beginning July 1, 2024, the hospital must affirm directly in its MRF that, to the best of its knowledge and belief, it has included all applicable standard charge information in its MRF, in accordance with §180.50 and that the information encoded is true, accurate, and complete as of the date indicated in the MRF.

In addition, CMS finalized a new general requirement that, beginning January 1, 2024, each hospital must make a good faith effort to ensure that the standard charge information encoded in the MRF is true, accurate, and complete as of the date indicated in the MRF.

Improving the Standardization of Hospital Machine-Readable File (MRF) Formats and Data Elements

[5] 45 CFR §180.40(a) provides general requirements for hospitals regarding what information a hospital must make public.
[6] 45 CFR §180.50(c) provides information regarding the required format that hospitals must meet when making public hospital standard charges for all items and services.

In the CY 2020 HPT final rule, CMS expressed concern that lack of uniformity in the way that hospitals display their standard charges will leave the public unable to meaningfully use, understand and compare standard charge information across hospitals. As a result, CMS established an initial set of rules for making public all standard charges in an MRF. However, since the regulation has been implemented (January 2021), CMS has received feedback that more standardization is needed considering both the template and additional contextual data elements.

To improve standardization, CMS finalized the following:

- *Requirement that hospitals encode all data items for additional data elements in their MRF:*
    - Unless otherwise specified, beginning July 1, 2024, each hospital must encode, as applicable, all standard charge information corresponding to each required data element in its MRF. Notably, CMS reiterates that the phrase "as applicable" does not mean that the reporting of information is optional.
- *Revise and expand the required data elements, including:*
    - Requiring a hospital to encode standard charge information for each of the following "general" data elements: Hospital name(s), license number, and location name(s) and address(es) under the single hospital license to which the list of standard charges apply. Location name(s) and address(es) must include, at minimum, all inpatient facilities and stand-alone emergency departments. The version number of the CMS template and the date of the most recent update to the standard charge information in the machine-readable file.
    - Additional requirements and clarifications for payer-specific negotiated charges.
    - Beginning January 1, 2025, if the standard charge is based on a percentage or algorithm, the MRF must also specify the estimated allowed amount for the item or service.

Required Data Elements Related to Hospital Items and Services

CMS finalized changes to require that, in a hospital's MRF, a hospital must encode a description of the item or service that corresponds to the standard charge established by the hospital, including a general description of the item or service, whether the item or service is provided in connection with an inpatient admission or an outpatient department visit, and beginning January 1, 2025, for drugs, the drug unit and type of measurement.

Required Data Elements Related to Item or Service Billing

CMS finalized a revision to the required data elements to include coding information as a required data element including any code(s) used by the hospital for purposes of accounting or billing for the item or service and corresponding code type(s) (e.g., the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), Revenue Center Codes (RCC), or other common payer identifier). Beginning January 1, 2025, the hospital must encode any modifier(s) that may change the standard charge that corresponds to a hospital item or service, including a description of the modifier and how it would change the standard charge.

Formatting Requirements for Display of Standard Charge Information Using a CMS Template

CMS finalized revisions to the formatting requirements and will require that, beginning July 1, 2024, the hospital's MRF must conform to a CMS template layout, data specifications, and data dictionary for purposes of making public the standard charge information. CMS indicates it will update the existing sample formats (CSV "tall", CSV "wide", and JSON schema) and data dictionary found on the CMS website to align with the new regulatory requirements.

Phased Implementation Timeline Applicable to the New Requirements Finalized

In the Final Rule, CMS outlines various implementation dates related to the HPT regulation. Tables 151A and 151B (pgs. 1462-1463) of the Final Rule provides a summary of the implementation timeline, including timing for adoption of the CMS template and encoding data elements.

Improving the Accessibility of Hospital MRFs

CMS indicates that it believes current policies are sufficient for purposes of manual search but may not be sufficient for automated searches. As a result, CMS finalized a requirement that the hospital ensure the public website includes a .txt file in the root folder that includes a standardized set of fields, including the hospital location name that corresponds to the MRF, the source page URL that hosts the MRF, a direct link to the MRF (the MRF URL), and hospital point of contact information. In addition, CMS finalized the requirement that the hospital ensures the public website includes a link included in the footer on its website, including but not limited to the homepage, that is labeled "Price Transparency" (instead of "Hospital Price Transparency") and links directly to the publicly available web page that hosts the link to the MRF.

Enforcement Process

In the Final Rule, CMS added activities that it may use to monitor and assess compliance, including that CMS may conduct a comprehensive compliance review of a hospital's standard charge information posted on a publicly available website, in addition to the ongoing use of audits. Also, CMS will require, upon the agency's request, an authorized hospital official to submit to CMS a certification to the accuracy and completeness of the standard charge information posted in the MRF. Also, CMS will require submission (upon the agency's request) of additional documentation as may be necessary to make a determination of hospital compliance.

CMS will also require that a hospital submit an acknowledgement of receipt of the warning notice in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital. In addition, should CMS take an action to address hospital noncompliance and the hospital is determined by CMS to be part of the health system, CMS indicates it may notify health system leadership of the action and may work with health system leadership to address similar deficiencies for hospitals across the health system.

Lastly, CMS finalized changes so that it may publicize on its website CMS's assessment of a hospital's compliance, any compliance action taken against a hospital, the status of such compliance action, or the outcome of such compliance action and notifications sent to health system leadership.

What's Next?

The OPPS tables for this CY 2024 Final Rule are available on the CMS website. Most provisions in the Final Rule go into effect January 1, 2024. Vizient's Office of Public Policy and Government Relations is happy to answer any questions you may have about provisions in this Final Rule. Please reach out to Jenna Stern, Associate Vice President, Regulatory Affairs and Public Policy in Vizient's Washington, D.C. office.