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INSIGHTS

CMS Proposes CY 2024 Hospital Outpatient PPS Rule

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On July 13, 2023, the Centers for Medicare and Medicaid Services (CMS) released their outpatient hospital and ambulatory surgery center (ASC) payment proposed rule for Calendar Year (CY) 2024. This memo will focus on the hospital outpatient sections of the rule. Comments on all portions of the proposed rule are due on September 11, 2023.

HOSPITAL PAYMENT CHANGES

For CY 2024, CMS is proposing a payment increase of 2.8%. This includes a 3.0% increase coupled with a 0.2% productivity adjustment. This equates to a $6 billion increase in payment for 2i1024. In addition, CMS is continuing the 2.0% reduction for all hospitals that fail to meet quality reporting requirements.

All wage index updates are consistent with the Inpatient Prospective Payment System updates. According to statute, the OPPS rule does continue paying Frontier Hospitals at a wage index of 1.0.

CMS is requesting comments on adding 97 new HCPC codes for payment purposes. The codes range from insertion of new types of urinary catheters to infectious DNA/RNA agent detection for various bacterium and fungi. The new codes are listed starting on Page 124 of the proposed rule.

340B-ACQUIRED DRUGS

CMS will continue payment the default rate of average sales price (ASP) plus 6%. According to CMS, this will ensure that drugs and biologicals will be paid the same rate whether they are acquired under a 340B program or not.

In addition, CMS is changing the coding of 340B drugs to use one modifier instead of two. Up through this year, hospitals could use either “JG” or “TB” as modifiers to identify a 340B purchased drug. CMS is proposing only the “TB” modifier be used after January 1, 2025.

PROPOSED OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS AND CRITICAL CARE SERVICES

CMS proposes to pay for clinic visits furnished by non-excepted off-campus provider-based departments (PBDs) at the physician fee schedule rate, rather than the hospital rate (specifically, HCPCS code G0463 - Hospital outpatient clinic visit for assessment and management of a patient.) This rate is about 60% less than the hospital rate. However, CMS exempts Sole Community Hospitals (SCHs) from this differential

and allows SCHs to be paid at the full outpatient rate. This rule continues this policy for SCHs for the next year.

PROPOSED MEDICARE PAYMENT FOR INTENSIVE OUTPATIENT PROGRAM

Last year, the 2023 consolidated appropriations bill created Medicare coverage for intensive outpatient services effective for items and services furnished on or after January 1, 2024. An intensive outpatient program (IOP) is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorders.

In this rule, CMS is working on implementing this new payment system for intensive outpatient services for hospital outpatient departments, community health centers (CHCs), federally qualified health centers (FQHCs), and rural health clinics (RHCs).

The agency defines intensive outpatient services as items and services "prescribed by a physician for an individual determined (not less frequently than once every other month) by a physician to have a need for such services for a minimum of 9 hours per week and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan." (P. 351)

The proposed rule sets out scope of benefits, billing, physician certification requirements, proposed payments, outlier payments, and the use for Opioid Treatment Programs (in an IOP_. CMS is asking for stakeholder comments on these ideas before they are rolled out.

SUPERVISION BY NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS AND CLINICAL NURSE SPECIALISTS OF CARDIAC, INTENSIVE CARDIAC AND PULMONARY REHABILITATION PROGRAM SERVICES FURNISHED TO OUTPATIENTS

The Balanced Budget Act of 2018 provided that nurse practitioners, physician assistants and clinical nurse specialists can supervise cardiac programs, intensive cardiac programs, and pulmonary rehabilitation programs furnished to outpatients. Prior to this, only physicians could supervise services in these programs. The proposed rule lays out the conditions of coverage for these programs to allow for NP/PA/CNS supervision.

The rule also allows for remote physician supervision through audio/video real-time telecommunications.

HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

In 2009, CMS implemented a Hospital Outpatient Quality Reporting program to measure data about the quality and efficiency of care received by Medicare beneficiaries. CMS is proposing the following changes to their 2024 OQR program.

Measure Removal

Left Without Being Seen (LWBS) – This measured the percentage of patients who left the ED without being seen. This measure was used as a proxy to measure ED overcrowding. CMS research has found this measure does not link to improved patient outcomes and the measure also does not give enough specificity to hospitals for use in creating an improvement plan. CMS would like to remove it beginning with CY 2024.

Measure Modification

CMS proposes to modify three measures:

- COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure. CMS is adding the words “up to date” in the measure to reflect the need for healthcare personnel to receive COVID-19 boosters.
- Cataracts: Improvement in Patient’s Visual Function Within 90 Days Following Cataract Surgery measure. CMS has laid out which visual function surveys are allowed to be used for this measure. CMS will now limit reporting to three survey instruments:
    - aThe National Eye Institute Visual Function Questionnaire-25 (NEI VFQ-25)
    - bThe Visual Functioning Patient Questionnaire (VF-14)
    - cThe Visual Functioning Index Patient Questionnaire (VF-8R)
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure. CMS is revising this measure to change from 50 years to 45 years based on new United States Preventive Services Task Force recommendations. So, the measure will now be “percentage of patients aged 45 years to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.”

New Measures

CMS is proposing adding three new quality measures. Below is a table of all measures proposed for 2024 reporting – the new measures are highlighted in blue.

CBE#	Measure Name
0514	MRI Lumbar Spine for Low Back Pain†
None	Abdomen CT – Use of Contrast Material 0669 Cardiac
0669	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
0496	Median Time for Discharged ED Patients (Previously referred to as Median Time from ED Arrival to ED Departure for Discharged ED Patients)
0661	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
None	HOPD Procedure Volume (Previously referred to as Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures)
0658	Colonoscopy Follow-Up Interval (Previously referred to as Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients)
1536	Cataracts Visual Function (Previously referred to as Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery)
2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
3490	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	Hospital Visits after Hospital Outpatient Surgery
None	OAS CAHPS – About Facilities and Staff
None	OAS CAHPS – Communication About Procedure
None	OAS CAHPS – Preparation for Discharge and Recovery
None	OAS CAHPS – Overall Rating of Facility
None	OAS CAHPS – Recommendation of Facility
3636	COVID–19 Vaccination Coverage Among Health Care Personnel

None	Breast Cancer Screening Recall Rates
None	ST-Segment Elevation Myocardial Infarction (STEMI) eCQM
None	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)
3663e	Excessive Radiation eCQM (Previously referred to as Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults eCQM)

CMS is also seeking public comment on new quality measures they would like to create around the ideas of promoting safety (patient and workforce), behavioral health, and telehealth.

REMOTE MENTAL HEALTH SERVICES FOR AT-HOME BENEFICIARIES

Last year, CMS created three new HCPC codes for billing for mental health services furnished by hospitals staff to beneficiaries in their homes through communication technology. This year, CMS seeks to clarify those codes and add a new group therapy code to further facilitate these questions.

The new group therapy code is C79xx.

HCPCS	Long Descriptor
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

CMS also reworded the existing mental health at home codes to clarify that they can be used for all visits, not just the initial visit.

HCPCS	Long Descriptor
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
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
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)

Hospitals will still need to conduct periodic In-person visits with some exceptions.

INPATIENT ONLY LIST

No services were removed from the IPO list for 2024,

PROPOSED UPDATES TO REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES

CMS is proposing multiple data submission changes for hospital price transparency to make it easier for hospitals and to make the subsequent data more useable. CMS is standardizing the charge information and data elements that hospitals must include in their machine-readable files (MRFs). They are releasing a template for all hospitals to use in their data transmission. CMS is also requiring a .txt file in the root folder that includes a direct link to the MRF to make accessibility easier for the agency. Finally, they are increasing their enforcement options including mandating hospitals acknowledge receipt of warning notices and publicizing more information about CMS enforcement activities.

CMS estimates that these requirements will create a one-time cost for each hospital of around $2,787.

POTENTIAL HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) AND OPPS PAYMENT ADJUSTMENTS FOR THE ADDITIONAL COSTS OF ESTABLISHING/MAINTAINING ESSENTIAL MEDICINES BUFFER STOCK

CMS is exploring a separate payment under the IPPS for establishing and maintaining access to a buffer stock of essential medicines to foster a more reliable, resilient supply of these medicines. CMS is considering this potential separate IPPS payment for cost reporting periods beginning as early as January 1, 2024. An adjustment under the OPPS could be considered for future years. CMS is requesting comments from stakeholders on this proposal.

REQUEST FOR PUBLIC COMMENTS ON POTENTIAL PAYMENT UNDER THE IPPS AND OPPS FOR ESTABLISHING AND MAINTAINING ACCESS TO ESSENTIAL MEDICINES

CMS is seeking comment on their idea of creating a separate payment for hospitals under the Inpatient Prospective Payment System to reimburse hospitals for establishing and managing access to a buffer stock of essential medicines. CMS is proposing that this payment will not be budget neutral.

We trust you found this summary useful. Please reach out to us with any questions.