Explaining CMS' 2024 OPPS and PFS Proposed Rules

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Chad Mulvany
Vice President, Federal Policy
California Hospital Association

Megan Howard
Vice President, Federal Policy
California Hospital Association

California Hospital Association

Welcome

Jaime Welcher
Education Program Manager
California Hospital Association

California Hospital Association

Questions

Online Questions: At any time, submit your questions in the Questions button at the bottom of your screen. We will take questions at the end of the presentation.

Welcome! Today's Speakers

Chad Mulvany
Vice President, Federal Policy

Chad Mulvany is vice president of federal policy for the California Hospital Association (CHA) and is responsible for providing leadership on federal hospital reimbursement issues and contributes on other federal regulatory matters. Based in CHA's Washington, DC Office, Chad collaborates with CHA's federal and state advocacy colleagues and national hospital associations on analysis and policy development for advocacy purposes.

Prior to joining CHA, Chad spent over 10 years as a Policy Director for the Healthcare Financial Management Association (HFMA) where he led HFMA's efforts on Medicare payment policy issues.

Welcome! Today's Speakers

Megan Howard
Vice President, Federal Policy

As vice president of federal policy for the California Hospital Association (CHA), Megan Howard is responsible for providing leadership on federal regulatory issues related to health care finance, quality and patient safety, and hospital and post-acute provider related issues.

Based in the Washington, DC office, Megan works with CHA's federal and state advocacy colleagues and national hospital associations on analysis and policy development for advocacy purposes. Prior to joining CHA, Megan worked as staff in the United States House of Representatives.

Agenda

- **Overview of Calendar Year (CY) 2024 Outpatient Prospective Payment System (OPPS) Proposed Rule**
  - Comments due to the Centers for Medicare & Medicaid Services (CMS) by 2 p.m. (PT) on Sept. 11
- **Overview of CY 2024 Physician Fee Schedule (PFS) Proposed Rule**
  - Comments due to CMS by 2 p.m. (PT) on Sept. 11


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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 414, 415, 418, 422, 423, 424, 425, 455, 489, 491, 495, 498, and 600

[CMS–1784–P]

RIN 0938–AV07

Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Share Savings Program Requirements; Medicare Advantage; Medicare an Medicaid Provider and Supplier Enrollment Policies; and Basic H Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Health Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This major proposed addresses: changes to the phy schedule (PFS); other change Medicare Part B payment pol ensure that payment system updated to reflect changes i practice, relative value of s changes in the statute; pay dental services inextricabl specific covered medical Medicare Shared Savings requirements; updates to Payment Program; Medi opioid use disorder serv by opioid treatment pr to certain Medicare an provider and supplier policies, electronic pr controlled substance D drug under a presc or an MA–PD plan u Use-Disorder Prever Opioid Recovery a Patients and Comm (SUPPORT Act); u Ambulance Fee S and the Medicare Data Collection the Inflation Re Consolidated A provisions; exp screening and pulmonary re rehabilitation rehabilitation expansion practitioners; appropriate use crite advanced diagnostic imaging; early release of Medicare Advantage risk adjustment data; a social determinants of health risk assessment in the annual

49552 Federal Register / Vol. 88, No. 145 / Monday, July 31, 2023 / Proposed Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 416, 419, 424, 485, 488, 489

Office of the Secretary

45 CFR Part 180

[CMS–1786–P]

RIN 0938–AV09

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for calendar year 2024 based on our continuing experience with these systems. In this proposed rule, we describe the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. This proposed rule also would update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program, the ASC Quality Reporting (ASCQR) Program, and the Rural Emergency Hospital Quality Reporting (REHQR) Program. This proposed rule would also establish payment for certain intensive outpatient services under Medicare, beginning January 1, 2024. In addition, this proposed rule would update and refine requirements for hospitals to make public their standard charge information and enforcement of hospital price transparency. We also propose to codify provisions of the Consolidated Appropriations Act, 2023, in Community Mental Health Centers Conditions of Participation (CoPs). We

propose to revise the personnel qualifications and add personnel Counselors and Marriage and Family Therapists in the CMHC CoPs. We also seek comment on separate payment under the inpatient Prospective Payment System (IPPS) for establishing and maintaining access to a buffer stock of essential medicines to foster a more reliable, resilient supply of these medicines. Finally, we propose to address any future revisions to the IPPS Medicare Code Editor (MCE), including any additions or deletions of claims edits, as well as the addition or deletion of ICD–10 diagnosis and procedure codes to the applicable MCE edit code lists, outside of the annual IPPS rulemakings. Additionally, we propose a technical correction to the Rural Emergency Hospital Conditions of Participation.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by September 11, 2023.

ADDRESSES: In commenting, please refer to file code CMS–1786–P. Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to https://www.regulations.gov. Follow the "Submit a comment" instructions.
2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1786–P, P.O. Box 8010, Baltimore, MD 21244–1810.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1786–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

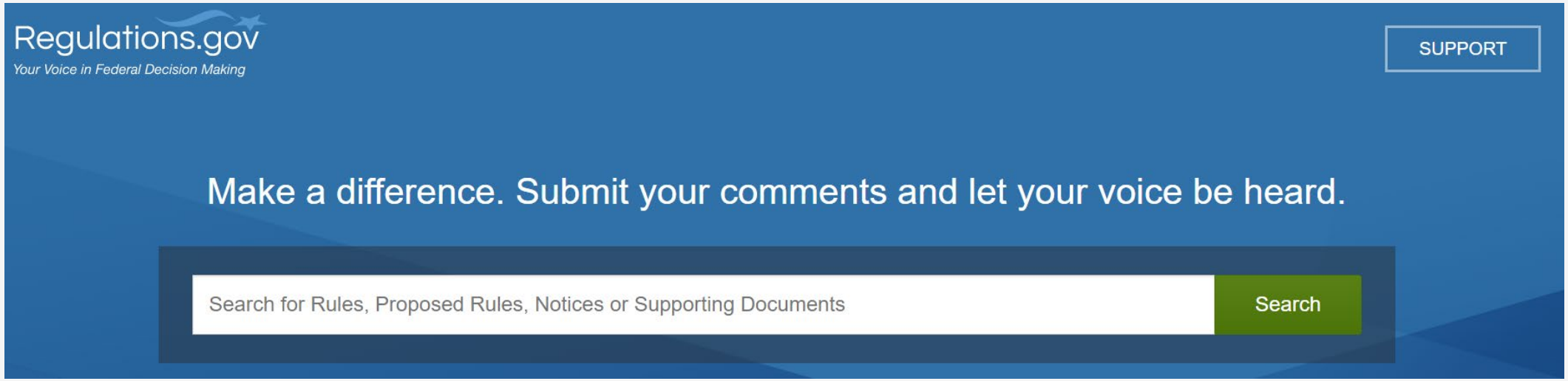
For information on viewing public comments, see the beginning of the SUPPLEMENTARY INFORMATION section.

FOR FURTHER INFORMATION CONTACT: Elise Barringer, Elise.Barringer@cms.hhs.gov or 410–786–9222. Advisory Panel on Hospital Outpatient Payment (HOP Panel), contact the HOP Panel mailbox at APCPanel@cms.hhs.gov. Ambulatory Surgical Center (ASC) Payment System, contact Scott Talaga via email at Scott.Talaga@cms.hhs.gov

or Mitali Dayal via email at Mitali.Dayal2@cms.hhs.gov. Ambulatory Surgical Center Quality Reporting (ASCQR) Program policies, contact Anita Bhatia via email at Anita.Bhatia@cms.hhs.gov. Ambulatory Surgical Center Quality Reporting (ASCQR) Program measures, contact Marsha Hertzberg via email at marsha.hertzberg@cms.hhs.gov. Biosimilars Packaging Exception, contact Gil Ngan via email at gil.ngan@cms.hhs.gov. Blood and Blood Products, contact Josh McFeeters via email at Joshua.McFeeters@cms.hhs.gov. Cancer Hospital Payments, contact Scott Talaga via email at Scott.Talaga@cms.hhs.gov. Cardiac Rehabilitation, Intensive Cardiac Rehabilitation and Pulmonary Rehabilitation Services, contact Nate Vercauteren via email at Nathan.Vercauteren@cms.hhs.gov. CMS Web Posting of the OPPS and ASC Payment Files, contact Chuck Braver via email at Chuck.Braver@cms.hhs.gov. Community Mental Health Centers (CMHC) Conditions of Participation, contact Mary Rossi-Coajou via email at Mary.RossiCoajou@cms.hhs.gov or Cara Meyer via email at Cara.Meyer@cms.hhs.gov. Composite APCs (Multiple Imaging and Mental Health), via email at Mitali Dayal via email at Mitali.Dayal2@cms.hhs.gov. Comprehensive APCs (C–APCs), contact Mitali Dayal via email at Mitali.Dayal2@cms.hhs.gov. COVID–19 Final Rules, contact Elise Barringer via email at Elise.Barringer@cms.hhs.gov. Hospital Outpatient Quality Reporting (OQR) Program policies, contact Kimberly Go via email Kimberly.Go@cms.hhs.gov. Hospital Outpatient Quality Reporting (OQR) Program measures, contact Janis Grady via email Janis.Grady@cms.hhs.gov. Hospital Outpatient Visits (Emergency Department Visits and Critical Care Visits), contact Elise Barringer via email at Elise.Barringer@cms.hhs.gov. Hospital Price Transparency (HPT), contact Terri Postma via email at PriceTransparencyHospitalCharges@cms.hhs.gov. Inpatient Only (IPO) Procedures List, contact Abigail Cesnik via email at Abigail.Cesnik@cms.hhs.gov. Inpatient Prospective Payment System (IPPS) Medicare Code Editor, contact Madey Hue via email at Marilu.Hue@cms.hhs.gov. Mental Health Services Furnished Remotely by Hospital Staff to

How to Comment

- Comments can be submitted online at www.regulations.gov
- Search “CMS-1786-P” for OPPS proposed rule
- Search “CMS-1784-P” for PFS proposed rule



CY 2024 OPPS Proposed Rule

Key Provisions

OPPS: Key Proposed Changes

The proposed increase in OPPS spending due only to changes in the 2024 OPPS rule is estimated to be approximately $1.92 billion.

The proposed rule includes policies that will:

- Increase the market basket by 2.8%
- Add 10 services to the inpatient-only (IPO) list
- Expand the partial hospitalization program (PHP) rate structure
- Establish an intensive outpatient program (IOP)
- Require template for hospital price transparency machine readable file
- Outline quality program requirements for rural emergency hospitals
- Update the requirements for the Hospital Outpatient Quality Reporting (OQR) Program

Proposed OPPS Conversion Factor update

The proposed OPPS conversion factor increases 2.2% over the prior year.

	Final CY 2023	Proposed CY 2024	Percent Change
OPPS Conversion Factor	$85.585	$87.488	+2.22%

Proposed CY 2024 Update Factor Component	Value
Market Basket Update	+3.0%
ACA–Mandated Productivity	–0.2 percentage points (PPT)
Wage Index Budget Neutrality (BN) Adjustment	+0.26%
Wage Index 5% Stop Loss BN	-0.25%
Pass–Through Spending/Outlier BN Adjustment	-.10%
Cancer Hospital BN Adjustment	+0.05%
Overall Proposed Rate Update	+2.22%

Impact on California Hospitals

Payments to California hospitals are projected to increase by $438 million.

OPPS CY 2024 Proposed Rule Analysis

CY 2024 Proposed Rule Compared to CY 2023 Final Rule

California

Impact Analysis	Dollar Impact	% Change
Estimated CY 2023 OPPS Payments	*$6,203,376,000*	
Marketbasket Update	$148,392,700	2.39%
ACA-Mandated Productivity Adjustment	($9,893,900)	-0.16%
Budget Neutrality Adjustments	($28,519,200)	-0.46%
Wage Index (Removal of Previous Bottom Quartile and Stop Loss (including rural floor))	($418,700)	-0.01%
Wage Index (Removal of Previous Rural Floor BN)	$28,403,900	0.46%
Wage Index (Removal of Previous Rural Floor Wage Index)	($37,185,000)	-0.60%
Wage Index (Change due to WI and LS prior to rural floor)	$27,020,400	0.44%
Wage Index (Current Rural Floor Wage Index Added)	$322,579,000	5.20%
Wage Index (Current Rural Floor Budget Neutrality Added)	($72,119,500)	-1.16%
Increasing Bottom Quartile Wage Index Values	$0	0.00%
Wage Index 5% Stop Loss	$6,642,600	0.11%
Change in Rural Add-On	$0	0.00%
APC Factor/Updates	$53,632,300	0.86%
Estimated CY 2024 OPPS Payments	*$6,641,910,600*	
Total Estimated Change From CY 2023 to CY 2024	**$438,534,600**	**7.07%**

The values shown in the table above do not include the 2.0% sequestration impact to all lines of Medicare payment authorized by Congress through FFY 2032. It is estimated that sequestration will reduce CY 2024 OPPS-specific payments by: $132,838,200

OPPS Outlier Payments

CMS uses CY 2022 claims to calculate a proposed CY 2024 outlier fixed–dollar threshold of $8,350.

- This is a decrease of approximately 3.2% 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 ambulatory payment classification (APC) payment amount when both the 1.75 multiplier threshold and the fixed–dollar threshold are met.
- Similar to prior years, CMS is targeting outlier payments to equal 1% of total OPPS payments.

Claims Used for Rate-Setting

After multiple years of using alternative data, CMS proposes to use the "normal" claims and cost report data to set relative APC weights for CY 2024.

- CMS proposes to use CY 2022 claims data and CY 2021 Healthcare Cost Report Information System (HCRIS) data from the December 2022 extract.

Wage Index

Similar to prior years, CMS proposes to use the final FFY 2024 IPPS post-reclassified wage index for the CY 2024 OPPS.

- Labor-related share remains at 60%.
- Proposes continuing the 5% cap on reductions to a hospital wage index for any reason to OPPS payments necessitating a .9975 BN factor.
- For non-IPPS hospitals paid under the OPPS for 2024, CMS proposes continuing its past policies of assigning the wage index that would be applicable if the hospital were paid under the IPPS and allowing the hospital to qualify for the out-migration adjustment.
- Similar to IPPS, CMS proposes to include any hospital reclassified as rural into the calculation of the statewide rural floor.
- CMS proposes to continue its “bottom quartile” wage index policy in a budget neutral manner.

Payment for Drugs, Biologicals, and Radiopharmaceuticals

California Hospital Association

Drugs, biologicals, and radiopharmaceuticals above the packaging threshold will continue to be paid at average sales price (ASP) plus 6%.

- CMS proposes a packaging threshold of $140.
- Separately payable drugs and biological products without pass–through status are paid wholesale acquisition cost (WAC) plus 3% instead of WAC plus 6%
- CMS proposes to continue to pay for therapeutic radiopharmaceuticals with pass–through payments status as well as blood clotting factors, based on ASP plus 6%.
- CMS proposes that beginning CY 2024, biosimilars would be exempt from the OPPS threshold packaging policy when their reference biologicals are separately paid.
- CMS proposes pass–through status to expire by December 31, 2023 for 43 drugs and biologicals, listed in Table 35; by December 31, 2024 for 25 drugs and biologicals listed in Table 36; and proposes to continue/establish pass–through status in CY 2024 to 42 drugs and biologicals shown in Table 37.

Non-Opioid Treatment Alternatives

CMS does not propose any changes to its packaging policies and separate payment for non-opioid treatment alternatives.

- Proposed rule indicates the Consolidated Appropriations Act (CAA) of 2023 requires separate payment for non-opioid pain relief treatments effective January 1, 2025 through December 31, 2027.
- Proposals to implement this will be included in the CY 2025 OPPS rule.
- CMS welcomes comment on whether there are any hospital outpatient department-specific payment issues it should take into consideration for 2025.

Drugs Acquired Under 340B

CMS proposes continuing to pay ASP +6% for separately payable drugs and biologicals acquired under the 340B program.

- CMS published a "remedy proposed rule" to address the reduced payment amounts to 340B hospitals under the reimbursement rates in the CYs 2018 through 2022 OPPS final rules.
  - The remedy proposed rule does not propose changes to CY 2024 OPPS drug payment policies nor the conversion factor but does propose changes to the calculation of the OPPS conversion factor beginning in CY 2025.
  - Please refer to CHA's executive and detailed summaries of the proposed remedy for additional information.
- CMS proposes only requiring a single modifier "TB" for 340B covered entities, effective January 1, 2025. The "JG" would remain effective through December 31, 2024 if a hospital desires to use it.

Payment for Off-Campus Provider-Based Department (PBD) Clinic Visits

CMS proposes to continue to apply a 60% reduction to the OPPS rate for excepted off–campus PBDs for basic clinic services in CY 2024.

- CMS proposes paying for intensive cardiac rehabilitation 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.
- Excepted PBDs continue to bill HCPCS code G0463 with modifier “PO”.

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.
- In the CY 2023 OPPS final rule, CMS created Healthcare Common Procedure Coding System (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 proposes to assign an additional 229 dental codes to APCs for CY 2024 that enable them to be paid for under OPPS.
- CMS proposes to package payments for dental services that are performed with another covered dental or medical service.

IPO List – Feedback Requested Re Deletions

For CY 2024, CMS does not propose to remove any services from the IPO list.

CMS seeks feedback on whether the following services are appropriate to remove from IPO list:

- *CPT code 43775*: Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)
- *CPT Code 43644*: Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and roux-en-y gastroenterostomy (roux limb 150 cm or less)
- *CPT Code 43645*: Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
- *CPT Code 44204*: Laparoscopy, surgical; colectomy, partial, with anastomosis

IPO List – Additions

CMS proposes adding the following services to the IPO list.

- *CPT X114T*: Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed
- *CPT 2X002*: Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments
- *CPT 2X003*: Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments
- *CPT 2X004*: Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed
- *CPT 619X1*: 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)

IPO List – Additions (cont.)

CMS proposes adding the following services to the IPO list.

- *CPT 7X000*: Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic
- *CPT 7X001*: Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report
- *CPT 7X002*: placement, manipulation of transducer, and image acquisition only
- *CPT 7X003*: interpretation and report only
- *CPT 0646T*: Transcatheter tricuspid valve implantation (ttvi)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed.

Additional Price Transparency Requirements

CMS proposes additional hospital price transparency requirements effective Jan 1, 2024, but with a two month implementation grace period.

CMS proposes the following definitions:

- *CMS template*: A CSV format or JSON schema that CMS makes available
- *Consumer-friendly expected allowed amount*: The average dollar amount that the hospital estimates it will be paid by a third-party payer
- *Encode*: Enter data items into the fields of the CMS template
- *Machine-readable file (MRF)*: A single digital file that is in a machine-readable format

Additional Price Transparency Requirements (cont.)

CMS proposes additional hospital price transparency requirements effective Jan 1, 2024, but with a two-month implementation grace period.

- *Affirming Completeness of Information*: Require each hospital affirm in its MRF it has included all applicable standard charge information

- *Improving MRF Accessibility*: Require hospitals to include a .txt file in the root folder that includes a direct link to the MRF and a link in the footer on its website that links directly to the publicly available webpage that hosts the link to the MRF.

Additional Price Transparency Requirements (cont.)

California Hospital Association

As part of its efforts to improve standardization, CMS is making the following proposals with respect to how information is presented in the MRF.

Current CMS Template vs. Proposed Additional Fields

Data Element	Sample Format	Proposed Rule
File Date	YES	YES
File Version	YES	YES
Hospital Name	YES	YES
Hospital License	YES	YES
Hospital Location	YES	YES
Hospital Address	*NO*	YES
Hospital Financial Aid Policy	YES	*NO*
Gross Charges	YES	YES
Cash Discounted Price	YES	YES
Payer-Specific Negotiated Charges*	YES	YES
Minimum and Maximum Deidentified Negotiated Charges	YES	YES
Consumer-Friendly Expected Allowed Amount	*NO*	YES
Item/Service Description	YES	YES
Billing/Accounting Codes, Modifiers, and Code Type	YES	YES
Billing Class	YES	*NO*
Setting (Inpatient or Outpatient)	YES	YES
Drug Unit and Type of Measurement	YES	YES

Request for Information (RFI): Aligning Price Transparency Programs

CMS asks the public to respond to questions on how the various transparency initiatives can be improved to help consumers make better informed decisions.

Questions Raised in the RFI Include:

1) How could the hospital consumer-friendly requirements be revised to align with other price transparency initiatives?

2) What elements of health pricing information do you think consumers find most valuable in advance of receiving care?

3) Given the new requirements and authorities through the Transparency in Coverage final rule and the No Surprises Act, respectively, is there still benefit to requiring hospitals to display their standard charges in a “consumer-friendly” manner under the Hospital Price Transparency regulations?

4) How effective are hospital price estimator tools in providing consumers with actionable and personalized information?

5) What is the minimum amount of personalized information that a consumer must provide for a price estimator tool to produce a personalized out-of-pocket estimate?

RFI: Maintaining Access to Essential Medicines

CMS believes it may be appropriate to pay separately for the additional costs associated with maintaining access to a buffer stock of essential medicines.

- Separate payments would be in addition to payment for the essential medicines.
- CMS could initially base the IPPS payment on the IPPS shares of the additional reasonable costs of a hospital to establish and maintain access to its buffer stock.
- Use of IPPS shares in payment adjustment is consistent with the use of these shares for the payment adjustment for domestic N95 respirators.
- Payments would be in accordance with reasonable cost principles through a biweekly payment with reconciliation during settlement of the cost report.
- CMS solicits public comments on a variety of additional considerations that would be associated with this policy.

Sole Community Hospital (SCH) Adjustment

CMS proposes to continue applying a 7.1% payment adjustment to all SCHs.

- This includes services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.
- Adjustment is budget neutral and is applied before calculating outliers and copayments.
- CMS proposes to maintain this for future years until data supports a change to the adjustment.

Cancer Hospital Adjustment

CMS proposes to continue providing payment increases to the 11 hospitals identified as exempt cancer hospitals.

- Proposes a target payment-to-cost ratio (PCR) equal to 0.88 for each cancer hospital
- CMS reduced the CYs 2020 through 2023 PCR of 0.89 (includes application reduction mandated by the 21st Century Cures Act) by an additional 1.0 percentage point.
- Applies for CY 2024 and subsequent years, until the target PCR equals the PCR of non-cancer hospitals calculated using the most recent data minus 1.0 percentage points
- Proposes a 0.05% adjustment to the CY 2024 conversion factor to account for this policy
- Table 5 shows the estimated hospital-specific payment adjustment for each 11 cancer hospitals

Areas with No Significant Changes Proposed

The proposed rule does not include significant changes in the following areas for CY 2024:

- Blood and Blood Products
- Composite APCs
- Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices
- Device Intensive Procedures
- Brachytherapy Sources
- Universal Low-Volume Policy
- High-Cost/Low-Cost Skin Substitutes

Partial Hospitalization Programs (PHPs) and Intensive Outpatient Programs (IOPs)

PHPs are intensive outpatient psychiatric programs that provide outpatient services in place of inpatient psychiatric care for patients that require a minimum 20 hours of PHP services per week

- PHP services are provided in a hospital outpatient department or community mental health center (CMHC)

The CAA of 2023 added a new Medicare benefit for IOP services for patients requiring a minimum of 9 hours of intensive behavioral health services per week

- CMS proposes IOP scope of benefits in line with PHP services; intensity of services is the key difference
- IOP services are not provided in lieu of inpatient psychiatric care
- IOP services may be provided in hospital outpatient departments, federally qualified health centers (FQHCs), rural health clinics (RHCs), and CMHCs

Proposed Payment for PHP and IOP Services

California Hospital Association

CMS proposes the following per diem payment rates for PHP and IOP Services:

	Final Payment Rate 2023	Proposed Payment Rate 2024	Percent Change
APC 5853: Partial Hospitalization (3+ services) for CMHCs	$142.70	$96.49	-32.38%
APC 5854: Partial Hospitalization (4+ services) for CMHCs	-	$151.36	-
APC 5851: Intensive Outpatient (3+ services) for CMHCs	-	$96.49	-
APC 5852: Intensive Outpatient (4+ services) for CMHCs	-	$151.36	-
APC 5863: Partial Hospitalization (3+ services) for Hospital-Based PHPs	$268.22	$280.80	+4.69%
APC 5864: Partial Hospitalization (4+ services) for Hospital–based PHPs	-	$364.04	-
APC 5861: Intensive Outpatient (3+ services) for Hospital–based IOPs	-	$280.80	-
APC 5862: Intensive Outpatient (4+ services) for Hospital–based IOPs	-	$364.04	-

IOP Services Provided in RHC and FQHC Settings

The CAA of 2023 established that payment for IOP services furnished by RHCs and FQHCs must equal the amount that would have been paid under Medicare for IOP services had they been covered outpatient department services furnished by a hospital.

CMS proposes to establish 3-service per day payment rates:

- For RHCs, the rate determined for APC 5861 (IOP 3 services per day) for hospital-based IOPs)
- For FQHCs, the lesser of a FQHC's actual charges or the rate determined for APC 5861.
    - For grandfathered tribal FQHCs, payment would be based on the lesser of the FQHC's actual charges or the outpatient per visit rate.

CMS seeks comment on whether the hospital-based IOP APC 5862 for four-service days would be appropriate for RHCs and FQHCs.

Remote Mental Health Services

- In the CY 2023 OPPS final rule, CMS established three HCPCS C-codes for mental health services furnished by hospital staff to beneficiaries in their homes through communications technology.
- CMS proposes to establish a new, untimed, HCPCS C-code describing group therapy, assigned to APC 5821, which pays $28.62.
- As required by the CAA of 2023, CMS proposes to delay its previously finalized policy that requires a patient receive an in-person visit within six months prior to the first time a mental health service is provided remotely, until Jan. 1, 2025.

Direct Supervision of Cardiac and Pulmonary Rehabilitation Services

- Under current OPPS policy, cardiac, intensive cardiac, and pulmonary rehabilitation services (CR, ICR, and PR) must be provided under the direct supervision of a physician.
- CMS proposes to modify its regulations to allow CR, ICR and PR services to be furnished under the direct supervision of a physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) — as required by the Bipartisan Budget Act of 2018 — beginning on Jan. 1, 2024.
- CMS proposes to extend COVID-19 public health emergency policies that allow direct supervision requirements for these services be met with the virtual presence (audio/video real-time communications technology) of the supervising physician, PA, NP, or CNS until Dec. 31, 2024.

Hospital Outpatient Quality Reporting (OQR) Program

CMS proposes to remove one OQR measure beginning with CY 2024:

- Left Without Being Seen (LWBS) Measure

CMS proposes modifications to three previously adopted measures:

- COVID-19 Vaccination Coverage Among Healthcare Personnel
- Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery (Cataracts Visual Function) Measure
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Colonoscopy Follow-Up Interval) Measure

CMS proposes to begin public display of data for the Median Time for Discharged ED Patients measure in 2024.

Hospital OQR Program (cont.)

CMS proposes to adopt three new measures to the OQR measure set:

- Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures Measure
  - Beginning with voluntary reporting in 2025 and mandatory reporting in 2026 (impacting CY 2028 payment determination)
- Risk-Standardized Patient-Reported Outcome-Based Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty in the HOPD Setting
  - Beginning with voluntary reporting in 2025 and 2026, and mandatory reporting in 2027 (impacting CY 2030 payment determination)
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults Measure (Excessive Radiation eCQM)
  - Beginning with voluntary reporting in 2025 and mandatory reporting 2026 (impacting CY 2028 payment determination)

Hospital OQR Program (cont.)

CMS seeks comments on potential future measurement topics for the OQR program:

- Promoting Safety for Patients and the Workforce
- Behavioral Health
- Telehealth

Questions

Physician Fee Schedule

Key Provisions

Physician Fee Schedule – Conversion Factor

CMS' proposed conversion factor for physician fee schedule payments is $32.75.

The conversion factor update reflects the following:

- Expiration of the 2.5% increase for services furnished in 2023 included in the CAA of 2023
- 0.00 percent update adjustment factor provided by Medicare Access and CHIP Reauthorization Act
- 1.25 percent increase provided by the CAA of 2023
- BN adjustment of -2.17%
- The proposed 2024 PFS CF is -3.6% lower than the 2023 conversion factor of $33.0607

Evaluation & Management (E/M) Split Billing

CMS again proposes to delay for a year the effective date of its "split billing" policy finalized in the CY 2022 rule for E/M visits.

Instead of only determining which provider performed the "substantive portion" of the visit based on total time, for CY 2024 one of the following may be used:

- History
- Physical exam
- Medical decision making
- Total time

Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation

CMS proposes implementing G2211 in CY 2024 as the moratorium is expiring.

G2211 Definition

Visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition (Add-on code, listed separately in addition to O/O E/M visit

G2211 Key Points

- G2211 is not be payable when reported with payment modifier-25.
- CMS now estimates G2211 will initially be billed with 38 percent of all O/O E/M visits initially, growing to 54 percent of O/O E/M visits.
- 90% of BN adjustment (1.95% of 2.17%) attributable to implementation G2211.

Care Navigation Codes

CMS adds several new codes to help support patients and their care givers.

- *Community Health Integration (GXXX1 and GXXX2)*: CMS proposes to create two codes describing community health integration (CHI) services performed by certified or trained auxiliary personnel, which may include a community health worker, incident to the professional services and under the general supervision of the billing practitioner.
- *Principle Illness Navigation (GXXX3 and GXXX4)*: CMS proposes a parallel set of services to the proposed CHI services, but focused on patients with a serious, high-risk illness who may not have social determinants of health (SDOH) needs.
- *SDOH Risk Assessment (GXXX5):* CMS proposes a HCPCS code to identify and value the work involved administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit.
- *Caregiver Training Services*: CMS believes a patient-centered treatment plan should account for the clinical circumstances where the treating practitioner believes the involvement of a caregiver is necessary to ensure a successful outcome and as appropriate, the patient agrees to caregiver involvement.

Appropriate Use Criteria (AUC)

CMS proposes to pause implementation of the AUC program for reevaluation and to rescind the current AUC regulations.

- CMS has exhausted all options for operationalizing the AUC program.
- Does not propose a time frame for recommencing implementation.
- Existing claims processing system can't automate AUC program.
- Many of the AUC program goals have been met by the Quality Payment Program and other initiatives such as the Medicare Shared Savings Program (MSSP).

Dental Services

CMS proposes that Medicare may cover dental services that are inextricably linked to other covered medical services.

These services include:

- Chemotherapy when used for cancer treatment
- CAR T-Cell therapy, when used in the treatment of cancer
- Administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer

CMS will cover under Part A or B:

- Dental examination performed as part of a comprehensive workup
- Medically necessary diagnostic and treatment services to eliminate an oral infection prior to or contemporaneously with any of the above services
- Services that are ancillary to these dental services, such as x-rays, administration of anesthesia, and use of the operating room

CMS also seeks comment on covering dental services associated with cardiac interventions and treatment of sickle cell disease.

MSSP: Benchmarking Changes

CMS proposes improvements to the benchmarking methodology.

Key Proposals:

Eliminate Negative Regional Adjustment: Mitigate the impact of the negative adjustment on the benchmark to support accountable care organizations (ACOs) caring for complex, high-cost beneficiaries.

- If the regional adjustment is positive, the ACO receives a regional adjustment.
- If the regional adjustment is negative, the ACO receives no regional adjustment.
- If the ACO is eligible for a prior savings adjustment, it would receive the prior savings adjustment as its final adjustment, without any offsetting reduction for the negative regional adjustment.

Changes to Prior Shared Savings: May change benchmarks through the prior savings adjustment in cases of compliance actions or revisions in shared savings amounts.

MSSP: Risk Adjustment

CMS proposes several changes to risk adjustment that if finalized are effective for agreements starting in 2024.

Key Proposals:

- *Transitions to V28 CMS-HCC*: Transition to the V28 CMS-HCC risk adjustment model
  - Align Performance and Benchmark Risk Adjustment: Use the CMS-HCC risk adjustment model(s) applicable to the calendar year corresponding to the performance year to calculate a Medicare fee-for-service (FFS) beneficiary's prospective HCC risk score for the performance year, and for each benchmark year of the ACO's agreement period.
- *Cap Regional Risk Score Growth*: Modify calculation of the regional update factor used to update the historical benchmark between benchmark year 3 and the performance year (PY) by capping an ACO's regional service area risk score growth through use of an adjustment factor to provide more equitable treatment for ACOs and for symmetry with the cap on ACO risk score growth.

MSSP: Assignment

CMS proposes changes to the assignment rules that would increase the number of underserved individuals attributed to MSSP ACOs.

Additional Details:

- *Adds 3rd Assignment Step*: In PY 2025, uses an expanded window to assign additional beneficiaries.
  - Expanded window is 24-months and includes the 12-month assignment window and the previous 12 months.
  - Medicare FFS beneficiaries not identified under the pre-step but who (i) received at least one primary care services with a participating NP, PA, or CNS in the ACO during the 12-month assignment window, and (ii) received during the 24-month expanded window at least one such service with an ACO professional who is a primary care physician or specialty designation physician would be assigned under step 3.
- *Attributable Services*: Adds new primary care services used in assignment.

MSSP: Quality Measurement and Scoring

The proposed rule makes several significant changes to quality measurement and reporting in the MSSP.

Key Proposals:

- *Medicare eCQMs*: Allows reporting under the Alternative Payment Model (APM) Performance Pathway (APP) on only Medicare beneficiaries using Medicare clinical quality measures.
- *Equity Adjustment*: Revises calculation of the health equity adjustment underserved multiplier.
- *CAHPS in Spanish*: Require Spanish language administration of the CAHPS for Merit-Based Incentive Payment System (MIPS) survey.
- *Promoting Interoperability*: Align certified electronic health record technology requirements for Shared Savings Program ACOs with MIPS.

Provider Enrollment: Revocations of Enrollment

CMS proposes a number of changes to the circumstances for which it can revoke a provider or supplier's enrollment.

Proposed Changes:

- *Non-Compliance Revocation Grounds*: Broadens the regulatory enrollment requirements that could subject a provider or supplier to revocation to those "described in this title 42" rather than just those "described in this subpart P".
- *Misdemeanor Convictions:* Agency may revoke a provider's or supplier's enrollment if they, or any owner, managing employee or organization, officer, or director thereof, have been convicted of a misdemeanor under federal or state law within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.
- *False Claims Act (FCA) Civil Judgements*: Proposes that it could revoke the enrollment of a provider or supplier if the provider or supplier, or any owner, managing employee or organization, officer, or director thereof, has had a civil judgment under the FCA imposed against them within the previous 10 years. Proposes factors to consider in this instance.

Provider Enrollment: Revocations of Enrollment (cont.)

CMS proposes a number of changes to the circumstances for which it can revoke a provider or supplier's enrollment.

Proposed Changes:

- *Violation of Provider and Supplier Standards:* Beyond general enrollment requirements, other regulations list detailed enrollment standards for independent diagnostic testing facilities (IDTF), durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, opioid treatment programs (OTP), home infusion therapy (HIT) suppliers, and Medicare diabetes prevention programs (MDPP). CMS proposes that it could revoke the enrollment of an IDTF, DMEPOS supplier, OTP, HIT supplier, or MDPP based on a violation of any of those other standards or conditions.
- *Existing Treasury Dept. Debt:* CMS proposes to exclude those cases where (1) the provider's or supplier's Medicare debt has been discharged by a bankruptcy court; or (2) the administrative appeals process concerning the debt has not been exhausted or the timeline for filing such an appeal, at the appropriate appeal level, has not expired.

Behavioral Health Services

- CMS proposes to implement provisions of the CAA of 2023 to establish coverage and payment for licensed marriage and family therapists and mental health counselors
- CMS proposes to establish payment for psychotherapy for crisis services
  - G-codes, GPFC1 (1st 60 minutes) and GPFC2 (each additional 30 minutes), for psychotherapy for crisis services furnished in any non-facility place of service (POS) other than physician office setting; payment at 150% of rate for physician office setting
- CMS proposes to allow general supervision for behavioral health services furnished incident to physician or NPP services in RHCs and FQHCs

Medicare Telehealth Services Proposals

CMS proposes several policies to implement the CAA of 2023, which further extended COVID telehealth flexibilities until Dec. 31, 2024:

- Continue waiver of geographic and location restrictions
- Continued coverage for certain services temporarily added to Medicare Telehealth Service list
- Allow services be furnished via audio-only telecommunications
- Allow physical therapists, occupational therapists, speech-language pathologists and audiologists to furnish telehealth services (and marriage and family therapists and mental health counselors beginning Jan. 1, 2024)
- Continued payment for telehealth services furnished by FQHCs and RHCs
- Delay in-person visit requirements for mental health services

Medicare Telehealth Service List

CMS proposes to replace existing Category 1, 2, or 3 telehealth service lists with "permanent" and "provisional" categories

- For 2024, CMS proposes to redesignate any services on the Medicare Telehealth Services List on a Category 1 or 2 basis to the permanent category
- Any service currently added on a "temporary Category 2" or Category 3 basis would be assigned to the provisional category
- CMS proposes to refine the process to evaluate eligibility for telehealth services but does not set any specific timing for reevaluation of services added to the telehealth list on a provisional basis.

CMS proposes to permanently add HCPCS code GXXX5 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes), contingent upon finalizing CMS' proposal to establish this code.

Medicare Telehealth Billing and Payment

Beginning Jan. 1, 2024, CMS proposes that telehealth claims be billed using the following POS indicators:

- POS “02” – Telehealth Provided Other than in Patient’s Home (Patient is not located in their home when receiving health services or health related services through telecommunication technology)
- POS “10” – Telehealth Provided in Patient’s Home (Patient is in a location other than a hospital or other facility where the patient receives care in a private residence when receiving health services or health related services through telecommunication technology)

- CMS proposes that claims billed with POS 10 will be paid at the higher non-facility rate and claims billed with POS 02 be paid at the lower facility rate
- For 2024, CMS proposes the originating site facility fee (Q3014) would be $29.92 (up from current $28.64)

Telehealth Services Furnished by Institutional Staff

- Under the COVID-19 PHE Hospital Without Walls waivers, CMS allowed hospitals to bill for certain services furnished remotely to patients in their homes including outpatient therapy services, diabetes self-management training (DSMT), and medical nutrition therapy (MNT).
- In a reversal of current post-PHE policy, CMS proposes to continue to allow institutional providers to bill for outpatient therapy, DSMT, and MNT services when furnished remotely in the same manner they would have during the PHE until Dec. 31, 2024.
- CMS seeks comments on current practices for these services when billed, including how and to what degree they continue to be provided remotely to beneficiaries in their homes.

Virtual Supervision Requirements

Direct Supervision for incident-to billing, certain diagnostic tests, pulmonary rehab, cardiac rehab, and intensive cardiac rehab services

- CMS proposes to extend COVID-19 PHE flexibilities to allow direct supervision requirements be met through virtual presence of the supervising physician using real-time audio/visual technology until Dec. 31, 2024

Supervision of Residents in Teaching Settings

- CMS proposes to allow the teaching physician to have a virtual presence in all teaching settings when the service is furnished virtually (e.g., a 3-way telehealth visit, with all parties in separate locations) until Dec. 31, 2024.
- CMS seeks comments about how telehealth services can be furnished in all residency training locations beyond 2024, including what clinical treatment situations are appropriate for the virtual presence of the teaching physician

Remote Monitoring Services

- CMS clarifies several policies related to Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) codes following the end of the COVID-19 PHE:
  - RPM services can only be furnished to established patients
  - RPM and RTM codes require data collection for at least 16 days in a 30-day period
  - Only one practitioner can bill for RPM/RTM CPT codes during a 30-day period
  - When multiple devices are provided, services with all the medical devices can be billed only once per patient per 30-day period and only when at least 16 days of data have been collected.
  - Practitioners may bill RPM or RTM, but not both RPM and RTM concurrently with care management services; RPM or RTM may be billed for the same patient with care management services if the time or effort is not counted twice.
  - RPM or RTM may be furnished to patients within a global surgery period for surgery if services unrelated to diagnosis for which surgery performed

Remote Monitoring Services (cont.)

CMS proposes to add certain RPM and RTM codes to list of RHC/FQHC care management services reimbursed under G0511

- Includes monthly monitoring (CPT 99454, 98976, 98977, 98978) and treatment management services (CPT 99457 and 98980)

CMS proposes to permit Medicare-enrolled PTs and OTs to bill for RTM services furnished by PTAs/OTAs under general supervision

- CMS seeks comment on whether general supervision should extend to all PTA/OTA services, not just RPM

RFI on digital therapeutics

Clinical Laboratory Fee Schedule (CLFS)

CMS proposes to revise CLFS private payor rate reporting requirements and phased payment reductions

- Data collection period: Jan. 1, 2019 – June 30, 2019
- Reporting period: Jan. 1, 2024 – March 31, 2024
  - Hospital outreach laboratories that billed at least $12,500 via TOB 14x during data collection period are “applicable laboratories” and must report payment data
- Payment reductions limited to 0% for 2021-2023 and 15% for 2024-2026

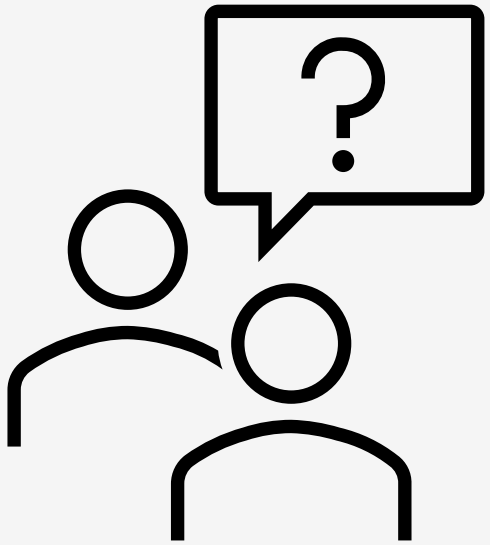
Questions

Contact

For additional questions, please contact:

Megan Howard
Vice President, Federal Policy
California Hospital Association
(202) 488-3742
mhoward@calhospital.org

Chad Mulvany
Vice President, Federal Policy
California Hospital Association
(202) 270-2143
cmulvany@calhospital.org



Thank You

Thank you for participating in today's webinar.

For education questions, contact:
education@calhospital.org