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AAOS CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule

On July 13, 2023, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center (OPPS/ASC) proposed rule. This proposed rule sets policies for hospital outpatient departments (HOPDs) and ambulatory surgical centers participating in the Medicare program. AAOS will be submitting comments by September 11, 2023.

Updates to OPPS and ASC Payment Rates

- CMS is proposing to increase payment rates by an Outpatient Department (OPD) fee schedule increase factor of 2.8%. This update is based on the proposed hospital market basket percentage increase of 3.0%, reduced by 0.2% point of productivity adjustment.
- In the CY 2019 OPPS/ASC final rule with comment period, CMS finalized the proposal to apply the productivity-adjusted hospital market basket update to ASC payment system rates for an interim period of 5 years (CY 2019 through CY 2023). CMS proposes to continue to apply the productivity-adjusted hospital market basket updates to ASC payment system rates for an additional two years. Using the proposed hospital market basket update, CMS is proposing to update the ASC rates for CY 20224 by 2.8%. for ASCs meeting relevant quality reporting requirements.

Changes to Inpatient Only List

- The inpatient only list, established during the initial implementation of the OPPS is a list that identifies services for which Medicare will only make payment when the services are provided in the inpatient hospital settings due to the invasive nature of the procedure, underlying physical condition of the patient, or the need for at least 24 hours of postoperative care/monitoring, prior to the patient being discharged safety.
- For CY 2024, CMS received various requests from several parties recommending particular services be removed from the IPO list. CMS conducted a clinical review and determined that there was not enough sufficient evidence based on the traditional longstanding criteria. Therefore, CMS is not proposing to remove any services from the IPO List for CY 2024.

OPPS Payments for Drugs Acquired Through 340B Program

- "On June 15, 2022, the Supreme Court held in American Hospital Association v. Becerra, that if CMS has not conducted a survey of hospitals' acquisition costs, it may not vary the payment rates for outpatient prescription drugs by hospital group. While the Supreme Court's decision addressed payment rates for CYs 2018 and 2019, it had implications for subsequent payment rates. Therefore, for CY 2023, we finalized a policy to revert to the default payment rate, which is generally ASP plus 6 percent, for 340B acquired drugs and biologicals and finalized a policy to pay for 340B acquired drugs and biologicals no differently than we pay for drugs and biologicals that are not acquired through the340B program."
- For CY 2024, CMS proposes to continue to pay the statutory default rate, which is generally average sales price (ASP) plus 6%, to 340B acquired drugs and biologicals, which is consistent with CMS finalized policy

for CY 2023. Therefore, drugs and biologicals acquired under the 340B program would be paid at the same payment rate as those drugs and biologicals not acquired under the 340B program.

Proposed OPPS Payment for Devices

- CMS extended the device pass-through status for a 1-year period beginning January 1, 2023, for device categories whose period of pass-through status would have ended on December 31, 2022, but instead will endon December 31, 2023.

TABLE 28: DEVICES WITH PASS-THROUGH STATUS EXPIRING IN THE FOURTH QUARTER OF 2023, IN 2024, OR IN 2025

HCPCS Code	Long Descriptor	Effective Date	Pass-Through Expiration Date
C1824*	Generator, cardiac contractility modulation (implantable)	1/1/2020	12/31/2023
C1982*	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2023
C1839*	Iris prosthesis	1/1/2020	12/31/2023
C1734*	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2023

- For CY 2024, CMS "received two device pass-through applications by the March 2023 quarterly application deadline for devices that have received Breakthrough Device designation from FDA and FDA marketing authorization for the indication for which they have a Breakthrough Device designation, and therefore are eligible to apply under the alternative pathway."
- Of the two-devices, BONESUPPORT AB submitted an application for a new device category for transitional pass-through payment status for CERAMENT® G. This device is a single-use implantable bone void filler combination device/drug that remodels into bone and elutes gentamicin.
- CMS invites the public to comment on whether CERAMENT® G meets the newness criterion, eligibility criterion. exclusion criterion, the device category criterion, and device pass- through payment criteria.
- CMS notes that "the applicant submitted cost information for two different device sizes (5 ml and 10 ml) for CERAMENT® G. Per the applicant, the average patient will require approximately 10 ml per procedure, with a weighted cost of $7,567.00 per patient."

Requirement in the Physician Fee Schedule CY 2024 Proposed Rule for HOPDs and ASCs to Report Discarded Amounts of Certain Single-dose or Single-use Package Drugs

- CMS stated that the Infrastructure Investment and Jobs Act amended a new subsection which "requires manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug."
- The CY 2024 PFS proposed rule includes a proposal that impacts HOPDs and ASCs. Comparable to CY 2023 notice in the OPPS/ASC proposed rule, CMS wants to ensure that all interested parties are aware of these

proposals. More information can be found in the Physician Fee Schedule (PFS) proposed rule for a full description of the proposed policy.
- CMS asks all interested parties to submit comments on any proposals related to implementation of section 90004 of the Infrastructure Act on the CY 2024 PFS proposed rule.

Quality Reporting Programs

Hospital Outpatient Quality Reporting (OQR) Program
- CMS proposes 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) beginning with the voluntary CYs 2025 and 2026 reporting periods, and mandatory reporting beginning with the CY 2027 reporting period/CY 2030 payment determination.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program
- CMS proposes re-adopt with modification the ASC Facility Volume Data on Selected ASC Surgical Procedures measure beginning with the voluntary CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. CMS also proposes 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 ASC Setting (THA/TKA PRO-PM) beginning with the voluntary CYs 2025 and 2026 reporting periods, and mandatory reporting beginning with the CY 2027 reporting period/CY 2030 payment determination

Rural Emergency Hospital Quality Reporting (REHQR) Program

- CMS proposes to (1) codify the statutory authority for the REHQR Program; (2) adopt and codify policies related to measure retention, measure removal, and measure modification; (3) adopt one chart-abstracted measure and three claims-based measures for the REHQR Program measure set and establish related reporting requirements beginning with the CY 2024 reporting period; (4) adopt and codify policies related to public reporting of data; (5) codify foundational requirements related to REHQR Program participation; (6) adopt and codify policies related to the form, manner, and timing of data submission under the REHQR Program; (7) adopt and codify a review and corrections period for submitted data; and (8) adopt and codify an Extraordinary Circumstances Exception (ECE) process for data submission requirements.
- CMS also seeks comments on the following potential measures and approaches for implementing quality reporting under the REHQR Program: (1) electronic clinical quality measures (eCQMs); (2) care coordination measures; and (3) a tiered quality measure approach.

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

- CMS "propose to amend several of hospital price transparency (HPT) requirements with the hopes of improve monitoring and enforcement capabilities by way of improving access to, and the usability of, hospital standard charge information, reduce the compliance burden on hospitals by providing CMS templates and technical guidance for display of hospital standard charge information; align, where

feasible, certain hospital price transparency requirements and processes with requirements and processes we have implemented in the Transparency in Coverage (TIC) initiative; and make other modifications to monitoring and enforcement capabilities that will, among other things, increase its transparency to the public."

Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor

- In the FY 2024 Inpatient Prospective Payment System (IPPS) proposed rule, CMS discussed the Medicare Code Editor (MCE), a software program that detects and reports errors in the coding of Medicare claims data.
- Beginning FY 2025, CMS proposes to remove discussions of the IPPS MCE from the annual IPPS rulemaking, to maintain consistency with the process that is used for updates to the Integrated Outpatient Code Editor (I/OCE) and other Medicare claims editing systems. CMS will generally address future changes or updates to the MCE through instruction to the MACs.

Comment Solicitation on Access to Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System

- The Access to Non-Opioid Treatments for Paint Relief, under the 2023 CAA, provides temporary additional payments for non-opioid treatments for pain relief. Specifically, for "non-opioid treatment for pain relief furnished on or after January 1, 2025, and before January 1, 2028, the Secretary shall not package payment for the non-opioid treatment for pain relief into payment for a covered OPD service and shall make an additional payment for the non-opioid treatment for pain relief."
- CMS seeks comment on whether there are any HOPD specific payment issues CMS should take into consideration for CY 2025.
- CMS also seeks comments on any drug, biological, or medical device that a commenter believes would meet the definition of a non-opioid treatment for pain relief.
- CMS notes that "the additional payment amount shall not exceed the estimated average of 18 percent of the OPD fee schedule amount for the OPS Service with which the non-opioid treatment for pain relief is furnished, as determined by the Secretary." For the purpose of calculating the payment limitation for each treatment, CMS invites comments on how they should determine the OPD services or groups of services with which non-opioid treatments for pain relief are provided. Other recommendations consistent with statutory requirements are welcomed by CMS.

Exclusion of REHs from the OPPS

- In the 2021 CAA, "Congress established Rural Emergency Hospitals (REHs), a new rural Medicare provider type, to help maintain access to rural outpatient hospital services and prevent rural hospital closures. These providers furnish emergency department and observation care, and other specified outpatient medical and health services, if elected by the REH, that do not exceed an annual per patient average of 24 hours. Hospitals are eligible to convert to REHs if they were CAHs or rural hospitals with not more than 50 beds participating in Medicare as of the date of enactment of the CAA."
- During the CY 2023 rulemaking cycle, CMS intended to revise the exclusion of REGs from payment under OPPS. However, this intended revision was inadvertently omitted. Therefore, CMS is now proposing to codify the exclusion of REHs from the OPPS

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Request for Public Comments on Potential Payment under the IPPS and OPPS for Establishing and Maintaining Access to Essential Medicines

- CMS "believes it is necessary to support practices that can curtail pharmaceutical shortages of essential medicines and promote resiliency in order to safeguard and improve the care hospitals are able to provide to beneficiaries."
- CMS is seeking comment on separate payment under IPPS, for establishing and maintaining access to a buffer stock of essential medicines to foster a more reliable, resilient supply of these medicines. CMS may also consider finalizing based on the review of comments received, as early as for cost reporting periods beginning on or after January 1, 2024. This separate payment would not be budget neutral. An adjustment under OPPS could be considered for future years.

Sources:

CY 2024 OPPS Proposed Rule

CY 2024 OPPS Fact Sheet