CY 2024 Medicare Hospital Outpatient Prospective Payment System (HOPPS)/Ambulatory Surgery Center (ASC) Final Rule (CMS-1786-FC)

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INTRODUCTORY SUMMARY AND BACKGROUND

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the Medicare Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgery Centers (ASCs) for calendar year (CY) 2024.

CMS is required to annually review and update the payment rates for services payable under HOPPS and in ASCs as specified in section 1833 of the Social Security Act. In addition, CMS is required to update the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program.

The prospective payment system (PPS) was developed and implemented to replace the reasonable cost-based payment methodology. HOPPS was implemented for services effective August 1, 2000. Under HOPPS, CMS pays for hospital Part B services on a rate-per-service basis according to the Ambulatory Payment Classification (APC) in which the service is assigned. The Healthcare Common Procedure Coding System (HCPCS), which includes Current Procedural Terminology (CPT®) codes, are used to identify, and group the services within each APC. APCs are organized by similar clinical relevance and resource use. Special payments for new technology items and services under HOPPS may be made by transitional pass-through payments and new technology APCs.

For ASCs, the surgical procedures on the ASC list for covered procedures are sorted into surgical specialty groups using CPT® and HCPCS code range definitions.

Certain hospitals are excluded from payment under HOPPS including critical access hospitals (CAHs); hospitals located in Maryland and paid under Maryland's All-Payer or Total Cost of Care Model; hospitals located outside the 50 states, the District of Columbia and Puerto Rico; and Indian Health Service (IHS) hospitals.

2024 HOPPS/ASC Final Rule

The CY 2024 proposed rule is 1,672 pages in length and located in its entirety at the following link: https://www.federalregister.gov/public-inspection/2023-24293/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment.

The format of this information is intended to summarize the final changes so readers are encouraged to view the document in its entirety for further details.

HOPPS Payment Rates

There are approximately 3,600 facilities paid under HOPPS including general acute care hospitals, children's hospitals, cancer hospitals, community mental health centers (CMHCs) and Ambulatory Surgery Centers (ASCs).

Typically, CMS utilizes the most updated claims and cost report data available to determine the HOPPS and ASC rate setting. The best available claims data is 2 years prior to the CY that is the focus of this rulemaking. Therefore, CMS has finalized their proposal to use CY 2022 claims data to set CY 2024 HOPPS and ASC payment rates.

Conversion Factor

The Outpatient Department (OPD) increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital charges. To set the HOPPS conversion factor (CF) for CY 2024, CMS finalized to increase the CY 2023 conversion factor of $85.585 by 3.1 percent, while adjusting the conversion factor to ensure any revisions made to the wage index and rural adjustment were made on a budget neutral basis. The finalized overall wage index budget neutrality factor was 0.9912, and an additional budget neutrality factor of 0.9997 to account for the proposed policy to cap wage index reduction for hospitals at 5 percent on an annual basis. Thus, the finalized CF for CY 2024 for hospitals that meet the hospital OQR program requirements is $87.382 in the calculation for national unadjusted rates. For those hospitals that fail to meet the hospital OQR program requirements, the CF is $85.687, which is a different in -1.695 in the CF relative to hospitals that meet the requirement.

Payment Rates

For CY 2024, CMS is finalizing HOPPS payment rates for hospitals that meet applicable quality reporting requirements by 3.1 percent under the Outpatient Department (OPD) fee schedule. This update is based on the projected inpatient hospital market basket increase of 3.3 percent minus a 0.2 percentage point adjustment for multi-factor productivity (MFP). Based on this increase, the estimated total payments to HOPPS providers for CY 2024 will be $88.9 billion. This represents a $6.0 billion increase from estimated CY 2023 HOPPS payments.

CMS is also finalizing their proposal to continue implementing a statutory 2.0 percent reduction for hospitals failing to meet the hospital outpatient quality reporting requirements set forth by the Hospital Outpatient Quality Reporting (OQR) Program. This is accomplished by applying a reporting factor of 0.9806 to the OPPS payments and co-payments for all applicable services.

Wage Index

Under HOPPS, the wage index is an assigned value that is used when determining the reimbursement amount for any given code (CPT® or HCPCS) in a specific hospital or ASC. This value will vary depending on the geographic location of the hospital or ASC and whether it is designated as an urban or rural location. The wage index is then valued with the labor adjustments (60 percent is the HOPPS labor-related portion, 40 percent is the HOPPS non-labor portion) and the APC assigned values to calculate the overall reimbursement rate for the service in a specific geographic location.

HOPPS wage index updates are proposed by CMS as part of the fiscal year (FY) 2024 inpatient prospective

payment system (IPPS) wage index adjustments and updated Office of Management and Budget (OMB) delineations. These changes are relative to the changes between urban and rural located hospitals. CMS is finalizing their proposal to continue a 5 percent cap on wage index decreases. Therefore, the wage index for FY 2024 would not be less than 95 percent of the finalized wage index for FY 2023 and would continue for subsequent years where the wage index for a given year would not be less than 95 percent of the final wage index for the prior year. This adjustment would also apply to outpatient hospitals. This cap ensures the changes to be finalized are made to "soften" any decreases that could have an overall impact on a specific value change.

CMS estimates the final rule update of the wage indexes (based on the FY 2024 IPPS proposed rule wage indexes) will result in increased payments of 0.0 percent for urban hospitals and increased payments of 1.2 percent for rural hospitals under HOPPS. For nonteaching hospitals, this update would result in an increased payment of 3.2 percent; minor teaching hospitals would result in increased payments of 3.0 percent; and major teaching hospitals would experience increased payments of 2.6 percent. These wage indexes include the continued implementation of the OMB labor market area delineations based on 2010 census data.

For CY 2024, CMS finalized their proposal to continue applying a wage index of 1.000 for frontier state hospitals (Montana, Wyoming, North Dakota, South Dakota, and Nevada) if the applicable wage index is less than 1.000. This policy has been in place since CY 2011. This ensures the lower population states are not "penalized" for reimbursement due to the low number of people per square mile when compared to other states.

CMS also finalized their proposal to use the FY 2024 IPPS post-reclassified wage index for urban and rural areas as the wage index for HOPPS to determine the wage adjustments for both the HOPPS payment rate, and the copayment rate for CY 2024. Those hospitals paid under OPPS, but not under IPPS, do not have an assigned hospital wage index under the IPPS. Therefore, non-IPPS hospitals paid under the OPPS are assigned a wage index as if they were paid under IPPS based on geographic location, any applicable wage index policies, and adjustments. CMS will continue this policy for CY 2024.

Rural Adjustments

The rural adjustment factor of 7.1% to the HOPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs) was established in CY 2000 in a budget neutral manner. CMS is finalizing their proposal to continue this current policy for CY 2024. This will continue until data supports a different factor should be applied. This payment adjustment will continue to exclude separately payable drugs, biologicals, brachytherapy sources, items paid at charges reduced to cost and devices paid under the pass-through payment policy. In addition, CMS is finalizing a budget neutrality factor for the rural adjustment at 1.0000.

340B Drug Discount Program Update

Section 340B of the Public Health Service Act (PHSA) allows participating hospitals and other providers to purchase certain covered outpatient drugs from manufacturers at discounted prices. In the CY 2018 HOPPS/ASC final rule with comment period, CMS reexamined the appropriateness of paying the average sales price (ASP) plus 6 percent for drugs acquired through the 340B Program, given that 340B hospitals acquire these drugs at steep discounts. Beginning January 1, 2018, CMS adopted a policy to pay an adjusted amount of ASP minus 22.5% for certain separately payable drugs or biologicals acquired through the 340B Program. CMS continued this policy in CYs 2019 through 2022.

CMS is finalizing their proposal to continue to reimburse drugs and biologicals purchased under the 340B program at the statutory default rate of average sales price (ASP) plus 6 percent. Therefore, drugs and biologicals not acquired under the 340B program will be paid at the same payment rates at those drugs and biologicals not acquired under the 340B device program. In previous rulemaking, CMS established specific modifiers to be utilized by hospitals reporting 340B acquired drugs and biologicals. Hospitals were instructed to report the "JG" modifier (Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes) or "TB" modifier (Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes for select entities) for informational purposes.

340B hospitals are required to report modifiers to identify drugs and biologicals acquired through the 340B program. Two modifiers, "JG" and "TB," have been used for this purpose. To streamline the reporting process CMS is implementing a single modifier. The use of a single modifier (TB) is seen as a more straightforward approach, especially since both "JG" and "TB" serve the same identification purpose. CMS believes this change would simplify the reporting process for hospitals, as they would only need to use one modifier to identify 340B acquired drugs. Hospitals have the option in 2024 to use modifier "JG" as they have been or can begin using modifier "TB" to assist in the transition of the discontinuation of modifier "JG", which will fully take effect January 1, 2025. The goal is to ensure accurate tracking of 340B program related drugs while reducing reporting burden for hospitals.

Due to litigation with previous 340B payment policies between the years of 2018 through 2022, CMS has published a separate final rule to remedy the reduced payment amounts during these years. This final rule does not affect payment policy for 340B acquired drugs in 2024; however, it does finalize changes to the conversion factor beginning in CY 2026 with a 0.5 percent reduction for approximately 16 years, until the monies owed are paid back in full. This final ruling can be located within separate document, CMS-1793-F located here: https://www.federalregister.gov/documents/2023/11/08/2023-24407/medicare-program-hospital-outpatient-prospective-payment-system-remedy-for-the-340b-acquired-drug.

Ambulatory Payment Classification (APC) Relative Payment Weights

It is required in Section 1833 of the Act to revise the relative payment weight for the APCs at least annually. APCs group services which are considered clinically comparable to each other in terms of resource utilization and associated cost. Ancillary services or items which are necessary components of the primary service are packaged into the APC rates and not separately reimbursed. Packaging encourages cost effectiveness and resource efficiency. CMS instructs providers to apply current procedure-to-procedure edits and then report all remaining services on the claim form.

CMS will only pay for those services which are considered not packaged into another service. Packaged services are those services that are "integral, ancillary, supportive, dependent and adjunctive" to the primary service. Under the current Comprehensive APC (C-APC) policy, CMS designates a service described by a CPT® or HCPCS code as the primary procedure when the service is identified by HOPPS status indicator (SI) "J1." There are services which are not covered under the C-APC policy and will not be paid, including certain mammography and ambulance services; and services that are required to be separately paid, including brachytherapy seeds and pass-through payment drugs and devices.

In addition to C-APCs, packaged services that are currently provided under HOPPS are reviewed annually in terms of integral, ancillary, supportive, dependent, or adjunctive items and services. For CY 2024, CMS finalized

their proposal to make no changes to the overall packaging policy. This means the continuation of conditionally packaging the costs of selected newly identified ancillary services into payment for a primary service.

New and Revised Codes

As part of the rulemaking process, CMS reviews new CPT® and HCPCS codes and assigns each an interim status indicator (SI) and APC. CPT® and HCPCS code changes that affect HOPPS are published through the annual rulemaking cycle, as well as the HOPPS quarterly update Change Requests (CRs). A summary of the current process for updating coding through the HOPPS quarterly update CRs, seeking public comments and finalizing codes under HOPPS is listed in the table below:

TABLE 11: COMMENT AND FINALIZATION TIMEFRAME FOR NEW AND REVISED HOPPS-RELATED HCPCS CODES

HOPPS Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April 2023	HCPCS (CPT and Level II codes)	April 1, 2023	CY 2024 OPPS/ASC proposed rule	CY 2024 OPPS/ASC final rule with comment period
July 2023	HCPCS (CPT and Level II codes)	July 1, 2023	CY 2024 OPPS/ASC proposed rule	CY 2024 OPPS/ASC final rule with comment period
October 2023	HCPCS (CPT and Level II codes)	October 1, 2023	CY 2024 OPPS/ASC final rule with comment period	CY 2025 OPPS/ASC final rule with comment period
January 2024	CPT Codes	January 1, 2024	CY 2024 OPPS/ASC proposed rule	CY 2024 OPPS/ASC final rule with comment period
	Level II HCPCS Codes	January 1, 2024	CY 2024 OPPS/ASC final rule with comment period	CY 2025 OPPS/ASC final rule with comment period

For the April 2023 update, there were 67 new HCPCS codes established and made effective on April 1, 2023. For the July 2023 update, a combination of 97 new CPT® and HCPCS codes were established and made effective July 1, 2023. For the October 2023 update, there were 64 new HCPCS codes established and made effective October 1, 2023. For the January 2024 update, CMS is soliciting comments on the new HCPCS codes that will be effective January 1, 2024, and are available in Addendum B to the CY 2024 OPPS/ASC final rule with comment.

Significance of code G0463

CMS is finalizing their proposal to continue using HCPCS code *G0463 (Hospital outpatient clinic visits for assessment and management of a patient)*, in APC 5012 (Level 2 Examinations and Related Services), as the standardized code for the HOPPS relative payment weights in CY 2024; and is proposed to continue to be

reimbursed a payment rate of 40% of the HOPPS rate for all off-campus outpatient departments, excepted and nonexcepted.

CMS is continuing to exempt excepted off-campus provider-based departments (PBDs) (departments that bill the modifier "PO" on claim lines) of rural Sole Community Hospitals (SCHs) and designated as rural for Medicare payment purposes. CMS recognizes the use of the clinic visit in some settings is supported even if it means the rate is higher than in other settings. This is due to concerns for beneficiaries and access to quality care. Therefore, to ensure access is possible, several special payment provisions for rural providers exist, and the exemption of the clinic visit payment policy is one of them. Rather than payment at 40 percent of the HOPPS rate, the clinic visit payment policy which applies a Physician Fee Schedule-equivalent payment rate for the clinic visit service would be paid at 100 percent of the HOPPS rate.

APC "2 Times Rule"

Items and services within an APC group cannot be considered resource utilization comparable if the highest mean cost for an item or service within the same APC group is more than 2 times greater than the lowest median cost. This is called the "2 times rule."

In the proposed rule, CMS identified 21 APCs in which the 2 times rule violation was found based on CY 2022 claims data available. The 2 times rule does not allow the codes to be assigned to an APC where the highest costing code is more than 2 times that of the lowest costing code. When a 2 times rule violation is identified, CMS and the Hospital Outpatient Payment (HOP) Panel will reassign codes or create a new APC. CMS only considers HCPCS codes that are significant based on the number of claims when determining if there is a 2 times rule violation. CMS is finalizing their proposal with modification to except 19 of the 21 APCs from the 2 times rule, as well as excepting 3 additional APCs (5734, 5743 and 5791) for a total of 22 APCs. The following table lists the APCs identified in violation of the 2 times rule in which CMS proposed to make an exception for CY 2024:

TABLE 12: FINAL CY 2024 APC EXCEPTIONS TO THE 2 TIMES RULE

APC	APC Group Title
5012	Clinic Visits and Related Services
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5301	Level 1 Upper GI Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5572	Level 2 Imaging with Contrast
5612	Level 2 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5674	Level 4 Pathology
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5734	Level 4 Minor Procedures
5741	Level 1 Electronic Analysis of Devices

5743	Level 3 Electronic Analysis of Devices
5791	Pulmonary Treatment
5811	Manipulation Therapy
5821	Level 1 Health and Behavior Services
5823	Level 3 Health and Behavior Services

New Technology APCs

When new technology is assigned a billing code, the establishment of a payment rate by CMS can be difficult because there is no claims data to determine utilization and cost by the hospital. Due to this, CMS created New Technology APCs which are similar to pass-through payments for new drugs, biologicals, radiopharmaceuticals and devices. The new technology is assigned to a temporary APC until claims data is available. Typically, this is a minimum of two years, but can be less if there is sufficient data available sooner. Once there is sufficient data, the new technology is moved to a clinically appropriate APC. Starting with the CY 2002 HOPPS final rule, criteria for assigning a complete or comprehensive service to a new technology APC was implemented:

1) Service must be truly new, meaning it cannot be appropriately reported by an existing HCPCS code assigned to a clinical APC and does not appropriately fit within an existing clinical APC;
2) Service is not eligible for transitional pass-through payment (although a truly new, comprehensive service could qualify for assignment to a new technology APC even if it involves a device or drug that could on its own, qualify for a pass-through payment); and
3) Service falls within the scope of Medicare benefits under the Act and is reasonable and necessary.

When new technology does have claims data but there are less than 100 claims a year, this is considered low volume. To establish a payment rate for Low Volume APCs, CMS will use up to four years of claims data to establish a payment rate. CMS will calculate the cost from the claims data using the value which is the highest, arithmetic mean cost, median cost, or geometric cost over the four-year period. Typically, a procedure remains in the new technology APC until sufficient claims data is received to justify reassignment to a clinically appropriate APC.

Consistent with current policy, for CY 2024, CMS is finalizing their proposal to retain services within the new technology APC groups until sufficient claims data is received to justify reassignment to a clinically appropriate APC. This policy provides flexibility to reassign a service to a clinical APC in less than 2 years if sufficient claims data is received.

Examples of new technology in which CMS addressed and finalized values include algorithm-driven services that assist practitioners in making clinical assessments. Providers pay for these services either on a subscription or per-use basis, and CMS refers to these services as Software as a Service (SaaS). In accordance with the SaaS Add-on Codes policy, SaaS CPT® add-on codes are assigned to the identical APCs and the same status indicator (SI) assignments as their standalone codes.

Of interest, CMS finalized their proposals without modification after consideration of comments received:

- To continue to assign code 47539 (*Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter)*, to APC 5361 (Level 1 Laparoscopy and Related Services).

- To continue to assign code 43275 *(Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s))* to APC 5302 (Level 2 Upper GI Procedures).

Device-Intensive Procedures

In the CY 2019 HOPPS final rule and for subsequent years, CMS modified criteria for device-intensive procedures to potentially allow a greater number of procedures to qualify as device-intensive. In years' past, one of the main criteria used to consider devices for device-intensive criteria was that only devices that remained in the patient (even temporarily) after the procedure would qualify. This is no longer a consideration. The modified criteria for device-intensive procedures is now in force:

- Procedure must involve implantable device assigned to a CPT® or HCPCS code;
- Device must be surgically inserted or implanted (either permanently or temporarily);
- Device offset amount must be significant, which is defined as exceeding 30 percent of the procedure's mean cost (down from 40 percent);
- Device has received FDA marketing authorization and investigational device exemption (IDE), and meets exemption from premarket review;
- Device is integral to the procedure performed;
- Device is used for one patient only;
- Device comes into contact with human tissue;
- Device is NOT equipment, an instrument, apparatus, implement, item of the type for which depreciation and financing expenses are recovered as depreciable assets; and
- Device is NOT material or supply furnished incident to a service (suture, surgical kit, scalpel or clip, other than a radiological site marker).

For consistency with CMS' broader proposal to use CY 2022 claims data for CY 2024 HOPPS and ASC ratesetting, CMS is finalizing their proposal to use CY 2022 claims data information to determine device offset percentages and assign device-intensive status. CMS is also finalizing to continue recognition of HCPCS C1889 (*Implantable/insertable device, not otherwise classified*) for billing of the device as part of a device intensive procedure when there is no specific Level II HCPCS Category C-code to represent it.

For device-intensive procedures in which a provider receives full or partial credit for a replaced device, the policy was finalized in CY 2017 and in subsequent years to reduce HOPPS payment. Currently, facilities are required to continue to report the credit amount in the amount portion for value code "FD" when the facility receives a credit for a replaced device that is 50 percent or greater than the cost of the device. For CY 2024, CMS is not proposing any changes to these policies regarding payment for no cost/full credit and partial credit devices.

Pass-Though Payments for Devices

In the CY 2017 HOPPS final rule and for subsequent years, CMS finalized the policy to allow for quarterly expiration of pass-through status for devices, in order to afford a pass-through payment period that is as close to a full 3 years as possible for all pass-through devices. In addition, a policy was finalized to package the costs of the expired pass-through devices into the procedure costs in which those devices are reported in the claims data for payment rate setting. Beginning for HOPPS device pass-through applications received on or after January 1, 2023, CMS has publicly posted online the completed application forms and related materials that are received from applicants, excluding certain copyrighted or other materials that applicants indicate cannot otherwise be released to the public.

There are currently 15 device categories eligible for pass-through payment. For CY 2024, CMS received 6 completed applications for device pass-through payments. CMS sought public comment on these applications based on current criteria. After consideration of the comments received, CMS is approving 4 applicants for device pass-through payment status in this final rule with comment period.

Changes to the Inpatient Only List

Procedures and services typically provided in an inpatient setting and not paid by Medicare under HOPPS are identified in the inpatient only (IPO) list. This list was created to identify procedures that *"were those determined to require inpatient care, such as those that are highly invasive, result in major blood loss or temporary deficits of organ systems (such as neurological impairment or respiratory insufficiency), or otherwise require intensive or extensive postoperative care. There are some services designated as inpatient only that, given their clinical intensity, would not be expected to be performed in the hospital outpatient setting. For example, we have traditionally considered certain surgically invasive procedures on the brain, heart, and abdomen, such as craniotomies, coronary-artery bypass grafting, and laparotomies, to require inpatient care."*

The complete IPO list can be found as Addendum E to the CY 2024 HOPPS final rule. Annual review of this list by CMS identifies services which should be removed or added based on the most recent data and medical evidence available, and the goal is to ensure inpatient only designations are consistent with current standards of practice. The current criteria used to determine if a procedure or service should be removed from the IPO and assigned to an APC group for payment under HOPPS includes:

- Most outpatient departments are equipped to provide the services to the Medicare population;
- The simplest procedure described by the code may be furnished in most outpatient departments;
- The procedure is related to codes that have already been removed from the IPO list;
- A determination is made that the procedure is being furnished in numerous hospitals on an outpatient basis;
- A determination is made that the procedure can be appropriately and safely furnished in an ASC and is on the list of approved ASC services or has been proposed by us for addition to the ASC list.

Over the years, some stakeholders have requested to maintain the IPO list as a tool in which to ensure quality of care for Medicare beneficiaries. Other stakeholders have requested to eliminate the IPO list and defer to the clinical judgment of physicians for decisions regarding site of service.

For CY 2024, CMS received several requests recommending specific services be removed for the IPO list. Of interest are CPT® codes 43775 *(Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy))*; 43644 *(Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less))*; and 43645 *(Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption)*. Based on the established criteria, CMS did not find sufficient evidence to support that these services met the criteria for removal. Therefore, CMS did not remove any services from the IPO list for CY 2024.

CMS proposed to add 9 services to the IPO list. After consideration of comments received, CMS finalized to add 9 services to the IPO list that were newly created by the AMA CPT® Editorial Panel for CY 2024. These services are represented by new CPT® codes 0709T, 22836, 22837, 22839, 61889, 76984, 76987, 76988, 76989, and 0646T, which will be effective on January 1, 2024. A clinical review of these services revealed they need a hospital inpatient admission, and as such, are not appropriate for payment under HOPPS. These codes will be

assigned to the status indicator ‘‘C’’ (Inpatient Only) for CY 2024. The full list of IPO services is provided by CMS on their website in Addendum E, part of the 2024 HOPPS final rule with comment period.

Hospital Price Transparency (HPT)

In CY 2020, CMS implemented 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.

CMS is finalizing their proposal to amend several HPT requirements in order to improve their ability to monitor and enforce capabilities by way of improving access to and the usability of hospital standard charge information; reduce compliance burden on hospitals by providing CMS templates and technical guidance; align certain price transparency requirements and processes; and make other modifications to CMS' monitoring and enforcement capabilities.

- Add Definitions for “CMS template”, “consumer-friendly expected allowed charges”, “encode”, and “machine-readable file” (MRF):
    - CMS template is a CSV format or JSON schema that CMS makes available for purposes of compliance with the requirements of § 180.40(a).
    - Encode is converting hospital standard charge information into a machine-readable format that complies with § 180.50(c)(2).
    - 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.
    - CMS is also finalizing, as proposed, technical revisions to replace references to “the file” and “the digital file” with the newly defined term “machine-readable file.”
- Revise the standard charge information and data elements that hospitals must include in their MRFs, as well as require hospitals to use a template developed by CMS in order to standardize and affirm the displayed MRF data. 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.
    - Has a machine-readable file which conforms to a CMS template layout, data specifications, and data dictionary for purposes of making public the standard charge information.
    - Must encode, as applicable, all standard charge information corresponding to each required data element in its MRF.
    - Must provide the hospital name(s), license number, and location name(s) and addresses(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 should also be included.
- For payer-specific negotiated charges, the payer and plan would be required as separate data elements:
    - 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 that item or service.
    - CMS finalized 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). Such code types may include, but are not limited to, 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.

- Phased implementation timeline applicable to the new requirements CMS is finalizing:
    - Table 151A within this final rule provides an implementation timeline for CMS template adoption and encoding data elements; and table 151B provides the implementation timeline for other new hospital price transparency requirements.
- A requirement that 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 for improved accessibility of the hospital MRF.
- Improvements to the enforcement process by updating CMS' methods to assess hospital compliance, requiring hospitals to acknowledge receipt of warning notices, working with health system officials to address noncompliance issues in one or more hospitals that are part of a health system, and publicizing more information about CMS enforcement activities related to individual hospital compliance:
    - CMS may now conduct a comprehensive compliance review of a hospital's standard charge information posted on a publicly available website, in addition to the use of audits which will be retained.
    - CMS will require, upon our 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.
    - CMS will require submission to us, upon our request, additional documentation as may be necessary to make a determination of hospital compliance.
    - CMS will 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.
    - CMS may publicize on its website information related to the following: (1) CMS' assessment of a hospital's compliance. (2) Any compliance action taken against a hospital, the status of such compliance action, or the outcome of such compliance action. (3) Notifications sent to health system leadership.

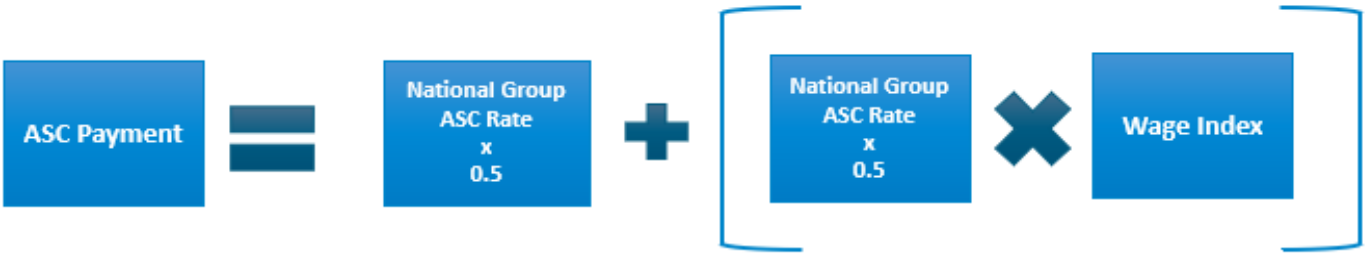
CMS finalized the effective date of these changes to the HPT regulation at 45 CFR part 180 will be January 1, 2024. However, the regulation text will specify later dates by which hospitals must be compliant with some of these new requirements, and CMS will begin enforcing those requirements on those specified dates.

Ambulatory Surgery Center (ASC) Payment Rates

For Ambulatory Surgery Center (ASC) payments CY 2019 through 2023, CMS has updated their policy for using the hospital inpatient market basket update to calculate rates. CMS is finalizing to extend this policy to update the ASC payment system using the hospital market basket update an additional 2 years, through CYs 2024 and 2025, as a continued response to the impacts of the COVID-19 public health emergency (PHE). Based on this current methodology to update the ASC payment system, CMS is finalizing to increase payment rates under the ASC payment system by 3.1 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. This finalized increase is based on a hospital market basket percentage increase of 3.3 percent reduced by a productivity adjustment of 0.2 percentage point. Based on this increase, the estimated total payments to

ASCs for CY 2024 will be $7.1 billion. This represents a $207 million increase from estimated CY 2022 ASC Medicare payments.

For CY 2024, CMS is adjusting the CY 2023 ASC conversion factor ($51.854) by a wage index budget neutrality factor of 1.0010 in addition to the productivity-adjusted hospital market basket update of 3.1 percent, discussed above, which results in a final CY 2024 ASC conversion factor of $53.514 for ASCs meeting the quality reporting requirements. For ASCs not meeting the quality reporting requirements, we are adjusting the CY 2023 ASC conversion factor ($51.854) by the wage index budget neutrality factor of 1.0010 in addition to the reduced productivity-adjusted hospital market 1.1 percent, which results in a final CY 2024 ASC conversion factor of $52.476 for ASCs not meeting the quality reporting requirements.



Complexity Adjustment Payments

CMS provides complexity adjustments to hospitals for certain services as part of comprehensive ambulatory payment classifications (C-APCs). When multiple C-APC services with the designated status indicator (SI) "J1" are performed together, CMS assigns the payment to the next highest paying C-APC of the same clinical family. A C-APC assigns payment for all ancillary services pertinent to the primary service assigned SI "J1" packaged into the primary code.

In the ambulatory surgical center (ASC) setting, C-APCs are not used because of system limitations for processing ASC claims for payment. ASC claims are processed as normal claims with separately payable procedure codes. When multiple procedures are performed together in an ASC, the procedure code with the lower payment is paid at 50 percent of the amount assigned. This is due to the duplicative use of resources while still providing payment for the work done. Add-on codes are not separately paid in the ASC.

Over the years CMS has received comments from stakeholders who were concerned about the payments for services in the ASC, already paid at a much lower rate than hospitals, and the lack of complexity adjustments incentivizes procedures in the hospital setting. In response for CY 2023, CMS evaluated differences in payments for HOPPS and ASC code pairs that included a primary procedure and add-on codes eligible for complexity adjustments under HOPPS in the ASC setting.

In the CY 2023 final rule, CMS finalized and codified a new ASC payment policy (with new regulatory text titled "Eligibility") that would apply to specific code combinations in which CMS would pay a higher rate to reflect the complexity and higher cost of the code combination. This policy is like the APC complexity adjustment which is applied to specific code combinations that are more resource intensive. CMS also finalized a policy of code combinations of a primary procedure code and add-on codes which are eligible for a complexity adjustment under HOPPS would also be eligible for a complexity adjustment in the ASC setting. Specifically, the ASC code combinations would include a separately payable surgical procedure code and one or more packaged add-on codes from the ASC Covered Procedures List (CPL) and ancillary services list.

As part of this special payment policy, CMS finalized their proposal to assign each eligible code combination a new C code that describes the primary and the add-on procedure(s) performed. C codes are temporary codes and are only valid for hospitals and ASCs. These codes cannot be billed in office-based settings or by physicians paid under the Medicare Physician Fee Schedule (MPFS). The new C codes are added to the ASC CPL; and when an ASC bills the C code, they will be paid the higher payment rate which includes the code combination for the more complex and higher cost procedure performed. CMS expects the list of codes to be adjusted annually to account for changes in procedures and payments.

If the procedure portion of a C code is performed with other services not part of the C code, CMS would apply the multiple procedure reduction as part of their policy. Device intensive procedures may also be assigned a C code and the calculation of the payment rate using the HOPPS complexity-adjusted C-APC rate would account for the portion of the device when determining the full adjustment.

For CY 2024, CMS finalized their proposal to continue the special payment policy and methodology for the HOPPS complexity-adjusted C-APCs. The full list of proposed ASC complexity adjustment codes for CY 2024 can be found in the ASC addenda and supplemental policy file on the CMS website:

https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/asc-regulations-and-notices.

Surgical Procedures Designated as Temporarily or Permanently Office-Based

CMS annually reviews and updates the covered procedures for which ASC payment is made, including those procedures which may be appropriate for ASC payment and those procedures which may be designated as office based. Of those procedures designated as office-based, they can either be permanent (being performed predominately in physicians' offices, i.e., more than 50 percent of the time); or temporary (designated as such in the CY 2019/CY 2020 final rules or fewer than 50 claims for procedure in data reviewed). CMS uses payment indicators as part of this designation:

- G2 – Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
- P2 – Office-based surgical procedure added to ASC list in CY 2008 or later with Medicare Physician Fee Schedule (MPFS) nonfacility practice expense (PE) relative value units (RVUs); payment based on OPPS relative payment weight.
- P3 – Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
- R2 – Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.

Typically, CMS would use the most updated claims and cost report data available to determine the OPPS and ASC rate setting. As a result, CMS is finalizing to use the CY 2022 for ASC ratesetting. Because of this, CMS has identified 4 surgical procedures that meet criteria for designation as permanently office based. CMS is also finalizing their proposal to continue to designate covered surgical procedures currently assigned a payment indicator of "P2" "P3" or "R2." Of interest are codes 92985 and 93986, which have a payment indicator of P2.

TABLE 120: CY 2024 PAYMENT INDICATORS FOR ASC COVERED SURGICAL PROCEDURES DESIGNATED AS PERMANENTLY OFFICE-BASED

CY 2024 CPT®/HCPCS Code	Long Descriptor	Final CY 2023 ASC Payment Indicator	Final CY 2024 ASC Payment Indicator*
93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	P2	P2*
93986	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study	P2	P2*

* Payment indicators were based on a comparison of the final rates according to the ASC standard ratesetting methodology and the CY 2024 PFS final rates. For a discussion of the final PFS rates, we refer readers to the CY 2024 PFS final rule.

Changes to the List of ASC Covered Surgical Procedures

CMS is required to review and update the ASC covered procedure list (ASC CPL) annually to determine whether procedures should be added or removed from the list. This process is often done in response to comments and concerns expressed by stakeholders. However, there are general "exclusion" criteria used in the determination for surgical procedures that:

1) Generally result in extensive blood loss;
2) Require major or prolonged invasion of body cavities;
3) Directly involve major blood vessels;
4) Are generally emergent or life threatening in nature;
5) Commonly require systemic thrombolytic therapy;
6) Are designated as requiring inpatient care under the e-CFR;
7) Can only be reported using a CPT® unlisted surgical procedure code; or
8) Are otherwise excluded in the regulations.

The current policy in place is intended to ensure "*that surgical procedures added to the ASC CPL can be performed safely in the ASC setting on the typical Medicare beneficiary*." Based on this review, CMS finalized to update the ASC CPL by adding 37 surgical procedures to the list for CY 2024, including 26 dental procedures and 11 additional procedures.

Submitting Comments

Comments to CMS regarding the HOPPS final rule must refer to file code CMS-1768-FC and be received no later than 5 pm EST January 1, 2024. Electronic and mail submissions are acceptable, electronic submissions are encouraged: http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.