2024 Hospital Outpatient Prospective Payment System – Final Rule Summary

On Thursday, November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) released the 2024 Hospital Outpatient Prospective Payment System (HOPPS) final rule, which includes payment cuts for radiation therapy services effective January 1, 2024.

Below is a summary of key issues impacting radiation oncology, including:

- Conversion Factor Update
- Use of Most Updated Claims Report Data for Rate Setting
- Ambulatory Payment Classifications (APC)
- Comprehensive Ambulatory Payment Classifications (C-APCs)
- Two-Times Rule Exception
- Brachytherapy Sources
- Hospital Outpatient Quality Reporting (OPQ) Program
- OPPS Payment for Dental Services
- Cancer Hospital Payment Adjustment
- OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Applications Received for Device Pass-Through Status for CY 2024
- New Technology APCs
- Health Equity

**Conversion Factor Update**
CMS will increase the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 3.1%. This increase is based on the hospital inpatient market basket percentage increase of 3.3% for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus a proposed 0.2% productivity adjustment.

Based on this update, CMS estimates that total payments to HOPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2024 will be approximately $88.9 billion, an increase of $6 billion compared to 2023 HOPPS payments.

**Use of Most Updated Claims Report Data for Rate Setting**
For CY 2024 rate setting, CMS is will use claims data from 2022 and the most updated cost report data available from the Healthcare Cost Report Information System (HCRIS), which includes data from 2021. This is the Agency’s typical data process, unlike in recent years when older data needed to be used due to the impact of COVID-19.

**Ambulatory Payment Classifications (APC)**
Although the HOPPS update is positive, many of the payment rates for traditional radiation oncology APCs in the 2024 HOPPS final rule will see cuts, unlike in the proposed rule in which CMS proposed modest increases for several radiation oncology APCs. It is important to remember that CMS’s projected rates are based on a partial claim file. When the Agency establishes final payment rates, the data set is

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1 In the Medicare hospital outpatient environment, hospital reimbursement is based on Ambulatory Payment Classifications or APCs. CMS assigns CPT codes to an APC based on clinical and resource use similarity. All services in an APC are reimbursed at the same rate. Cost data collected from OPPS claims are used to calculate rates. Certain services are considered ancillary, and their costs are packaged into the primary service. Packaged services do not receive separate payment. For example, in the hospital outpatient environment, imaging is not paid separately when reported with treatment delivery services.
more complete. The APC payment rates are directly linked to the geometric mean cost data for the services included in each APC, which can cause the APC payment rates to fluctuate between the proposed and final rules and for certain APCs to be lower than what was proposed. These data sets are an independent variable from the HOPPS update, so even though 2024 will see a 3.1% increase overall, individual APCs can still face cuts. This is similar to the Medicare Physician Fee Schedule in which the Conversion Factor may increase, but cuts are seen at the procedural level.

Additionally, declines in radiation oncology reimbursement under HOPPS are likely to continue in future years, as the growing use of hypofractionation causes declines in hospital technical revenue. These continued cuts underscore the need for ASTRO’s proposed ROCR Program, which would secure stable payment rates, improve upon already excellent quality, and reduce disparities.

Below is a list of radiation oncology APCs with their 2024 payment rates:

<p>| Radiation Oncology - Ambulatory Payment Classification 2024 Payment Rates |
|-----------------------------|--------------------------|--------------------------|--------------------------|</p>
<table>
<thead>
<tr>
<th>APC</th>
<th>Descriptor</th>
<th>2023 Rate</th>
<th>2024 Rate</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>5611</td>
<td>Level 1 Therapeutic Radiation Treatment Preparation</td>
<td>$133.38</td>
<td>$129.41</td>
<td>-2.98%</td>
</tr>
<tr>
<td>5612</td>
<td>Level 2 Therapeutic Radiation Treatment Preparation</td>
<td>$358.72</td>
<td>$352.41</td>
<td>-1.76%</td>
</tr>
<tr>
<td>5613</td>
<td>Level 3 Therapeutic Radiation Treatment Preparation</td>
<td>$1,340.67</td>
<td>$1,321.58</td>
<td>-1.42%</td>
</tr>
<tr>
<td>5621</td>
<td>Level 1 Radiation Therapy</td>
<td>$122.39</td>
<td>$114.37</td>
<td>-6.55%</td>
</tr>
<tr>
<td>5622</td>
<td>Level 2 Radiation Therapy</td>
<td>$262.93</td>
<td>$256.33</td>
<td>-2.51%</td>
</tr>
<tr>
<td>5623</td>
<td>Level 3 Radiation Therapy</td>
<td>$572.47</td>
<td>$561.45</td>
<td>-1.92%</td>
</tr>
<tr>
<td>5624</td>
<td>Level 4 Radiation Therapy - HDR Brachytherapy</td>
<td>$721.72</td>
<td>$683.84</td>
<td>-5.25%</td>
</tr>
<tr>
<td>5625</td>
<td>Level 5 Radiation Therapy - Proton Therapy</td>
<td>$1,323.22</td>
<td>$1,353.02</td>
<td>2.25%</td>
</tr>
<tr>
<td>5626</td>
<td>Level 6 Radiation Therapy - SBRT</td>
<td>$1,767.45</td>
<td>$1,701.89</td>
<td>-3.71%</td>
</tr>
</tbody>
</table>

**Comprehensive Ambulatory Payment Classifications (C-APCs)**

Under the C-APC policy, CMS provides a single payment for all services on the claim regardless of the span of the date(s) of service. Conceptually, the C-APC is designed so there is a single primary service on the claim, identified by the status indicator (SI) of “J1”. All adjunctive services provided to support the delivery of the primary service are included on the claim. While ASTRO supports policies that promote efficiency and the provision of high-quality care, we have long expressed concern that the C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC.

Below is a comparison table of the 2023 payment rates and 2024 payment rates for the radiation oncology services in several key C-APCs:

| C-APC 5627 Level 7 Radiation Therapy |
Although many radiation oncology C-APCs see a modest increase in the final rule, ASTRO remains concerned that these services are still undervalued due to the C-APC methodology. Despite efforts to encourage the Agency to value these services more accurately, CMS remains committed to the methodology and does not intend to modify it for radiation oncology services. ASTRO will continue to educate CMS on the impact the C-APC methodology has on radiation oncology services, particularly brachytherapy.

C-APC 5415 Level 5 Gynecologic Procedures
ASTRO, as well as other commenters, expressed concerns with the C-APC methodology for surgical insertion codes for brachytherapy treatment, noting that this impacts beneficiary access to brachytherapy in the Hospital Outpatient Department (HOPD) setting. The C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC, and the rates do not accurately or fully reflect the services and costs associated with the primary procedure. However, CMS continues to believe that the current methodology is appropriately applied to these procedures.

ASTRO specifically asked that CPT code 57155 Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy and CPT code 58346 Insertion of Heyman capsules for clinical brachytherapy be moved to a higher paying C-APC, but the Agency found that CPT code 57155 is appropriately paid in its current category (C-APC 5415) based on claims data. For CPT code 58346, there were too few claims (less than 100), so it did not meet the significance threshold for reevaluation.
SpaceOAR Hydrogel Procedure (APC 5375)
In 2023, CPT code 55874 Transperineal placement of biodegradable material, periprostatic, single, or multiple injection(s), including image guidance, when performed was assigned to APC 5375 with a payment rate of $4,702.18. For 2024, CMS proposed to move it to APC 5376, which has a payment rate of $4,959.89. However, after reviewing the claims data, CMS found that CPT code 55874 had an average cost of about $6,634, which is more similar to APC 5375 (with a cost of about $5,067) than APC 5376 (with a cost of about $9,022). Therefore, it will remain in APC 5375.

Two-Times Rule Exception
CMS established two-times rule criteria within the APC methodology that requires that the highest calculated cost of an individual procedure categorized to any given APC cannot exceed two times the calculated cost of the lowest-costing procedure categorized to that same APC. However, the Agency can exempt any APC from the two-times rule for any of the following reasons:
- Resource homogeneity
- Clinical homogeneity
- Hospital outpatient setting utilization
- Frequency of service (volume)
- Opportunity for upcoding and code fragments

Based on CY 2022 claims data, CMS will apply the two-times rule exception to APC 5612 Level 2 Therapeutic Radiation Treatment Preparation and APC 5627 Level 7 Radiation Therapy. This means that although there are individual procedures within these APCs that violate the two-times rule, CMS is allowing them to remain assigned to the same groups.

Brachytherapy Sources
In the 2024 HOPPS final rule, CMS will continue to base the payment rates for brachytherapy sources on the geometric mean costs for each source, which is consistent with the methodology used for other services under HOPPS. Additionally, the Agency used the costs derived from 2022 claims data to set the 2024 payment rates for brachytherapy sources because that is the claims data used for most other items in the proposed rule. However, C2645 Brachytherapy planar source, palladium-103, per square millimeter had insufficient claims data, so the Agency will continue the payment rate of $4.69 per mm$^2$ in CY 2024.

CMS proposes to pay for HCPCS codes C2698 Brachytherapy source, stranded, not otherwise specified and C2699 Brachytherapy source, non-stranded, not otherwise specified, at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively on a per-source basis. For 2024, the rates are $41.82 for C2698 and $34.99 for C2699. This is a 9.6% change in payment for C2698 and a -1.2% change for C2699 from the 2023 rates.

In the 2022 HOPPS final rule, CMS established a Low Volume APC policy for brachytherapy APCs (also for New Technology APCs and clinical APCs—it is universal). For those APCs with fewer than 100 single claims that can be used for rate setting purposes in the existing claims year, CMS uses up to four years of claims data to establish a payment rate for each item or service, which is a similar methodology that the Agency applies to low volume services assigned to New Technology APCs. Further, the Agency calculates the cost based on the greatest of the arithmetic mean cost, median cost, or geometric mean cost.

Table 46 includes the five brachytherapy APCs that CMS is designating as Low Volume APCs for CY 2024.
Table 46: Cost Statistics for Final Low Volume APCs Using Comprehensive (OPPS) Rate Setting Methodology for CY 2024

<table>
<thead>
<tr>
<th>APC</th>
<th>APC Description</th>
<th>CY 2022 Claims Available for Rate Setting</th>
<th>Geometric Cost without Low Volume APC Designation</th>
<th>Final Median Cost</th>
<th>Final Arithmetic Mean Cost</th>
<th>Final Geometric Mean Cost</th>
<th>CY 2024 Final APC Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2632</td>
<td>Iodine I-125 sodium iodide</td>
<td>0</td>
<td>---*</td>
<td>$31.74</td>
<td>$61.83</td>
<td>$41.06</td>
<td>$61.83</td>
</tr>
<tr>
<td>2635</td>
<td>Brachytx, non-str, HA, P-103</td>
<td>21</td>
<td>$97.56</td>
<td>$58.38</td>
<td>$60.78</td>
<td>$54.74</td>
<td>$60.78</td>
</tr>
<tr>
<td>2636</td>
<td>Brachy linear, nonstr, P-103</td>
<td>1</td>
<td>$60.16</td>
<td>$22.17</td>
<td>$55.57</td>
<td>$32.95</td>
<td>$55.57</td>
</tr>
<tr>
<td>2642</td>
<td>Brachytx, stranded, C-131</td>
<td>82</td>
<td>$93.94</td>
<td>$76.36</td>
<td>$100.23</td>
<td>$79.27</td>
<td>$100.23</td>
</tr>
<tr>
<td>2647</td>
<td>Brachytx, NS, Non-HDRIr-192</td>
<td>2</td>
<td>$415.40</td>
<td>$201.69</td>
<td>$358.12</td>
<td>$166.75</td>
<td>$358.12</td>
</tr>
</tbody>
</table>

*For this rule, there are no CY 2022 claims that contain the HCPCS code assigned to APC 2632 that are available for CY 2024 OPPS/ASC rate setting.

**OPPS Payment for Dental Services**
For CY 2024, CMS is assigning over 240 HCPCS codes describing dental services to various clinical APCs to align with Medicare payment provisions regarding dental services adopted in the CY 2024 Medicare Physician Fee Schedule (MPFS) final rule.

*Go Deeper*
As in the MPFS, payment can be made only when the dental service is inextricably linked to other covered services. The Agency noted that HOPDs would only receive payment for a dental service assigned to an APC when the appropriate Medicare Administrative Contractor (MAC) determines that the service meets the relevant conditions for coverage and payment.

**Hospital Outpatient Quality Reporting (OPQ) Program**
For the Hospital OQR Program measure set, CMS is finalizing the proposal to, among other things, adopt the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) measure, beginning with CY 2025 reporting period on a voluntary basis, then shifting to mandatory reporting beginning with the CY 2027 reporting period/CY 2029 payment determination (one year later than proposed).

**Cancer Hospital Payment Adjustment**
CMS will continue to provide additional payments to cancer hospitals so that their payment-to-cost ratio
(PCR) after the additional payments is equal to the weighted average PCR for other OPPS hospitals. As required by law, CMS must reduce the weighted average PCR by 1.0 percentage point; however, because of the impact of the COVID-19 PHE on claims and cost data, CMS kept the target PCR at 0.89 in 2021, 2022, and 2023. Beginning in 2024, CMS will again decrease the target PCR by 1.0 percentage point each year until it is the same as the PCR for non-cancer hospitals. In 2024, the target PCR will be 0.88 for cancer hospitals.

Go Deeper
Since the inception of OPPS, Medicare has paid the 11 hospitals that meet the criteria for “cancer hospitals” under OPPS for covered outpatient hospital services to reflect their higher outpatient costs. Cancer hospitals receive additional payments so that their payment-to-cost ratio (PCR) after the additional payment is equal to the weighted average PCR for other OPPS hospitals using the most recently submitted or settled cost report data. The actual final amount of the CY 2024 cancer hospital payment adjustment for each cancer hospital will be determined at cost report settlement and will depend on each hospital’s CY 2024 payments and costs form the settled CY 2024 cost report.

In 1983, when the IPPS was established, Congress authorized CMS to develop regulations for exceptions to IPPS for hospitals involved extensively in cancer research and treatment. After HOPPS was created in 1999, these cancer hospitals received special treatment under it as well. Essentially, the Congressional action ensures that PPS Exempt Cancer Hospitals receive the same amount they would have received pre-HOPPS—they’re permanently “held harmless.”

Table 6 below, excerpted from the rule, shows the estimated percentage increase in OPPS payments to each cancer hospital for CY 2023, due to the cancer hospital payment adjustment policy.

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>Hospital Name</th>
<th>Estimated Percentage Increase in OPPS Payments for CY 2024 due to Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>050146</td>
<td>City of Hope Comprehensive Cancer Center</td>
<td>58.0%</td>
</tr>
<tr>
<td>050660</td>
<td>USC Norris Cancer Hospital</td>
<td>34.2%</td>
</tr>
<tr>
<td>100079</td>
<td>Sylvester Comprehensive Cancer Center</td>
<td>41.9%</td>
</tr>
<tr>
<td>100271</td>
<td>H. Lee Moffitt Cancer Center &amp; Research Institute</td>
<td>25.0%</td>
</tr>
<tr>
<td>220162</td>
<td>Dana-Farber Cancer Institute</td>
<td>43.1%</td>
</tr>
<tr>
<td>330154</td>
<td>Memorial Sloan-Kettering Cancer Center</td>
<td>58.1%</td>
</tr>
<tr>
<td>330354</td>
<td>Roswell Park Cancer Institute</td>
<td>19.1%</td>
</tr>
<tr>
<td>360242</td>
<td>James Cancer Hospital &amp; Solove Research Institute</td>
<td>14.5%</td>
</tr>
<tr>
<td>390196</td>
<td>Fox Chase Cancer Center</td>
<td>20.8%</td>
</tr>
<tr>
<td>450076</td>
<td>M.D. Anderson Cancer Center</td>
<td>44.8%</td>
</tr>
<tr>
<td>500138</td>
<td>Seattle Cancer Care Alliance</td>
<td>39.4%</td>
</tr>
</tbody>
</table>

OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals

Proposed Payment Policy for Therapeutic Radiopharmaceuticals
CMS is finalizing its proposed payment policy for therapeutic radiopharmaceuticals. Medicare pays for separately payable therapeutic radiopharmaceuticals under the Average Sales Price (ASP) + 6%.

methodology adopted for separately payable drugs and biologicals. If ASP information is unavailable for a therapeutic radiopharmaceutical, CMS will provide pass-through payment at weighted average cost (WAC) + 3%. If WAC information also is not available, the Agency will provide payment for the pass-through radiopharmaceutical at 95% of its most recent average wholesale price (AWP).

Solicitation of Comments on OPPS Packaging Policy for Diagnostic Radiopharmaceuticals

The Agency sought comments on potential modifications to its packaging policy for diagnostic radiopharmaceuticals to ensure equitable payment and continued beneficiary access. It also sought comments on how the OPPS packaging policy for diagnostic radiopharmaceuticals has impacted beneficiary access, including whether there are specific patient populations or clinical disease states for whom this issue is especially critical. Finally, CMS asked for comments on the proposed new approaches to payment for diagnostic radiopharmaceuticals under the OPPS.

CMS received considerable interest in this solicitation of comments, and it intends to further consider the comments for future rulemaking.

Go Deeper

Under OPPS, CMS packages several categories of nonpass-through drugs, biologicals, and radiopharmaceuticals, regardless of the cost of the products. Interested parties have raised concerns regarding this policy for diagnostic radiopharmaceuticals, believing that the packaged payment rate is inadequate after pass-through status expires, especially when the diagnostic radiopharmaceutical is high-cost and has low utilization. Additionally, commenters have been concerned that packaging payment for precision diagnostic radiopharmaceuticals in the outpatient setting creates barriers to beneficiary access for safety net hospitals serving a high proportion of Medicare beneficiaries and hospitals serving underserved communities.

Applications Received for Device Pass-Through Status for CY 2024

One pass-through application of interest to radiation oncology was Praxis Medical’s CytoCore. Per the applicant, at the time of biopsy, the motorized CytoCore device contains gears and an internal motor that spins a minimally invasive needle to increase cellular yields in fewer passes. The applicant further explained that CytoCore is vacuum-assisted and can easily be operated using one hand. According to the applicant, the primary use is for biopsy of any suspicious thyroid nodule.

CMS determined that CytoCore is a biopsy apparatus and, as such, is a material or supply furnished incident to a service. In accordance with the device eligibility requirements, it did not meet the eligibility criteria for device pass-through status.

Go Deeper

CMS establishes specific criteria for hospitals to receive pass-through payments for devices that offer substantial clinical improvement in treatment of Medicare beneficiaries. Devices must meet the following criteria: 1) receive FDA approval or clearance; 2) the device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part; and 3) the device is an integral part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted, or applied in or on a wound or other skin lesion. Finally, the device must not be an item for which depreciation and financing expenses are recovered and it is not a supply or material furnished incident to a service.

In addition to meeting criteria for pass-through payment, a device must meet specific criteria for CMS to establish a new category of devices. The criteria for establishing a new category of devices require that
the device is not appropriately described by any other category; and that it has an average cost that is not insignificant relative to the payment amount for the procedure or service with which the device is associated by demonstrating:
1) The estimated average reasonable costs of devices in the category exceeds 25% of the applicable APC payment amount for the service related to the category of devices;
2) The estimated average reasonable cost of the devices in the category exceeds the cost of the device-related portion of the APC payment amount for the related service by at least 25%; and
3) The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount for the device exceeds 10% of the APC payment amount for the related service.

New Technology APCs
A procedure of interest to radiation oncology within the proposed New Technology APCs was Bronchoscopy with Transbronchial Ablation of Lesion(s) by Microwave Energy. Effective January 1, 2019, CMS established HCPCS code C9751 (Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (for example, aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s)). This microwave ablation procedure utilizes a flexible catheter to access the lung tumor via a working channel and may be used as an alternative procedure to a percutaneous microwave approach. Based on its review of the New Technology APC application for this service and the service’s clinical similarity to existing services paid under the OPPS, the Agency estimated the likely cost of the procedure would be between $8,001 and $8,500.

Due to very low claims numbers in past years, the Agency used its equitable adjustment authority to calculate the geometric mean, arithmetic mean, and median costs to determine an appropriate payment rate. The payment rate calculated using this methodology fell within the cost band for New Technology APC 1562 (New Technology—Level 25 ($3501–$4000)). Therefore, it assigned this code to APC 1562 for CY 2021, 2022, and 2023.

For 2024, since there were no new claims reported, the Agency will continue to use the same method to determine the APC and payment rate, which is APC 1562 (New Technology—Level 25 ($3501–$4000)) with a payment rate of $3,750.50.

Go Deeper
Services that are assigned to New Technology APCs are typically new services that do not have sufficient claims history to establish an accurate payment for the services. One of the objectives of establishing New Technology APCs is to generate sufficient claims data for a new service so that it can be assigned to an appropriate clinical APC. Some services that are assigned to New Technology APCs have very low annual volume, which CMS considers to be fewer than 100 claims. It considers services with fewer than 100 claims annually to be low-volume services because there is a higher probability that the payment data for a service may not have a normal statistical distribution, which could affect the quality of its standard cost methodology that is used to assign services to an APC. In addition, services with fewer than 100 claims per year are not generally considered to be a significant contributor to the APC rate setting calculations and, therefore, are not included in the assessment of the 2-times rule.

Where utilization of services assigned to a New Technology APC is low, it can lead to wide variation in payment rates from year to year, resulting in even lower utilization and potential barriers to access to new
technologies, which ultimately limits the Agency’s ability to assign the service to the appropriate clinical APC. To mitigate these issues, CMS decided it was appropriate to use its equitable adjustment authority to adjust how it determined the costs for low-volume services assigned to New Technology APCs. For New Technology APCs with fewer than 100 single claims at the procedure level that can be used for rate setting, CMS would apply its proposed methodology for determining a low volume APC’s cost (as previously mentioned in the section on Brachytherapy Services), choosing the “greatest of” the median, arithmetic mean, or geometric mean at the procedure level, to apply to the individual services assigned to New Technology APCs and provide the final New Technology APC assignment for each procedure.

**Health Equity**
CMS sought comment on how to structure an impact analysis that addresses how OPPS and ASC changes may impact beneficiaries of different groups. It currently presents OPPS impacts by provider type, rural versus urban area, geographic region, teaching status, and ownership type. The Agency is interested in what health equity questions it can examine within these existing categories to better understand the health equity impact of its policies.

Commenters were supportive of CMS efforts to incorporate health equity elements into future impact analyses and provided other recommendations for policies to promote health equity using the OPPS. The Agency will take these suggestions into consideration for future rulemaking.

**Additional information about the 2024 HOPPS final rule can be found at the following links:**

A display copy of the proposed rule can be found at: [https://public-inspection.federalregister.gov/2023-24293.pdf](https://public-inspection.federalregister.gov/2023-24293.pdf)
