On July 13, 2023, the Centers for Medicare & Medicaid Services released the proposed rule for the CY 2024 Hospital Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center (ASC) Payment System. A fact sheet accompanies the release of the rule. Comments are due September 11, 2023.

Payment Rate Updates for OPPS and ASC Payment System – p. 875

The agency is proposing to update the payment rate for outpatient hospitals by 2.8%. Pay rates for outpatient hospitals are based on the hospital market basket update which is projected to increase by 3%. The rate is then reduced by 0.2% to account for the productivity adjustment. The payment update is the same for ASCs which will see an increase of 2.8% for services provided to Medicare beneficiaries. The detailed economic impact may be found on page 875 of the display copy of the proposed rule.


In the OPPS rule, the agency does not propose or discuss the policies associated with discarded drug amounts and instead refers readers to the CY 2024 Medicare Physician Fee Schedule, page 417. The reporting of certain discarded amounts of drugs was created by Section 90004 of the Infrastructure Investment and Jobs Act of 2021. This provision requires manufacturers to refund the CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. The agency is accepting comments on this policy through the physician fee schedule proposed rule.

Payment for Dental Services – p. 442

To conform with the MPFS changes in policy to cover certain dental services when related to specific conditions, CMS has proposed an additional 229 dental procedure codes to clinical ambulatory payment classifications (APCs). Table 53 on page 448 lists those dental procedures. Of importance, the agency reiterates that simply because a procedure is assigned to an APC does mean that it is covered by Medicare. Medicare Administrative Contractors (MACs) will make the determination if the dental procedure meets program requirements and conditions for coverage and then payment. CMS will continue to evaluate the claims data and solicit comments as payment for dental services continues to evolve.

Request for Public Comments on Potential Payments under the IPPS and OPPS for Establishing and Maintaining Access to Essential Medicines – p. 818

CMS recognizes that drug shortages force hospitals to incur additional financial and labor costs as well as delay or revise patients’ treatment regimens. Given the role of hospitals in procuring essential medicines, their procurement preferences can directly influence manufacturer behavior and be leveraged to foster a more resilient supply chain. To better support supply chain resiliency, hospitals
can maintain a sufficient inventory of essential medicines, which can be used in the event of a disruption or demand increase, and source them from multiple manufacturers. CMS seeks to support practices that may limit shortages of essential medicines and promote resiliency to safeguard and improve the care delivered to Medicare beneficiaries.

CMS seeks comments 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. This payment could be implemented for cost reporting periods beginning on or after January 1, 2024, and would not be budget neutral. In the future, the agency will consider an OPPS adjustment.

Establishing and Maintaining a Buffer Stock of Essential Medicines

The report Essential Medicines Supply Chain and Manufacturing Resilience Assessment, as developed by the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) prioritized 86 essential medicines as critical for minimum patient care in acute settings or important for acute care or important for acute care of respiratory illnesses/conditions, with no comparable alternative available. The only chemotherapeutic on this list is cyclophosphamide.

To mitigate the effect of shortages of critical medicines, hospitals can maintain a buffer stock of these medicines, which CMS recognizes will come at greater cost than procuring them through methods that are susceptible to supply chain disruptions. Therefore, the agency is considering separate payment for the costs of establishing and maintaining access to a buffer stock of essential medicines.

Potential Separate Payment Under IPPS and OPPS for Establishing and Maintaining Access to a Buffer Stock of Essential Medicines

An additional separate payment to support a buffer stock of essential medicines would be made in addition to the payment for the medicines themselves. Based on the information available, it is difficult to quantify the additional resources required. CMS could 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 initially through a payment separate from the cost of the medicine itself. This information could be reported in the cost report to calculate a Medicare payment for the cost specific to each hospital. These payments could be provided biweekly as interim lump-sum payments to the hospital and would be reconciled at cost report settlement.

Additionally, CMS seeks comments on the following questions:

- How effective would this potential payment policy be at improving the resiliency of the supply chain for essential medicines and the care delivery system? How could it be improved, either initially or through future rulemaking? Are there suggested alternative pathways for establishing similar separate payments?
- It is possible that there are additional resource costs, perhaps contractual, to establishing and maintaining access to a buffer stock of more expensive domestically manufactured essential medicines compared to non-domestically manufactured ones. What type of additional hospital resource costs are involved in establishing and maintaining access to domestically manufactured essential medicines compared to non-domestically manufactured ones? Are there alternative approaches that might better recognize the increased resource costs for a hospital to establish and maintain access to a buffer stock of domestically manufactured
essential medicines? How might any suggested alternatives be better at improving the resiliency of the supply chain for essential medicines and the care delivery system? What standard should be used to define domestic manufacturing for suggested alternatives? Specifically, would the international trade rule of “substantial transformation” be appropriate to define domestic manufacturing, if that product were substantially transformed in the U.S.? Would hospitals have sufficient access to that information when making procurement decisions or doing reporting to CMS?

- Are the 86 essential medicines prioritized in the report *Essential Medicines Supply Chain and Manufacturing Resilience Assessment* the appropriate initial list of essential medicines for this potential payment policy? How often should HHS consider updating the respective list used for establishing these potential additional payments? For example, HHS expects it may update the essential medicine list every two years. Should that be the frequency for purposes of administering these additional payments? Also, what additional criteria should be considered when determining whether the list should be updated?

- Should HHS consider expanding the list of essential medicines used in establishing these potential additional payments to include essential medicines used in the treatment of cancer?

- Is a 3-month supply the appropriate amount of supply for the buffer stock, or should an alternative duration be used? We recognize that a 3-month supply may not be feasible in all circumstances, given various factors, including, but not limited to, the shelf life of certain essential medicines. What additional considerations, if any, are needed?

- In general, how much of a buffer stock of these essential medicines are hospitals currently maintaining across different hospital types and regions (whether directly, or contractually through distributors or other partners)? Are there unique circumstances for safety net hospitals that should be taken into consideration in any potential payment policy?

- What type of additional hospital resource costs are involved in establishing and maintaining access to a buffer stock of essential medicines? To what degree, and under what circumstances, might hospitals use contractual arrangements? What type of contractual arrangements might be used?

- What flexibilities should exist for implementing buffer stock practices?

- What immediate impacts on the supply of essential medicines could be expected upon implementation of this potential policy? What steps, if any, would need to be taken to mitigate risks of possible demand-driven shortages as a result of implementation of such a policy?

- While the availability of essential medicines is always critical, it is especially the case for emergencies. Should there be a separate payment adjustment to more acutely address supply issues that emerge specific to the case of preparedness as a pandemic or other public health emergency emerges?

- How should such a policy be considered for essential medicines that are currently in shortage, and thus potentially not appropriate for arranging to have buffer stock? What steps, if any, would need to be taken if an eligible essential medicine enters shortage while such a policy is in place?