Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

July 16, 2023

Proposed Update to the CY 2024 Hospital Outpatient and ASC Prospective Payment Systems Released

The Centers for Medicare & Medicaid Services (CMS) have issued a proposed rule to update policies and payment rates for services to hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) beginning January 1, 2024 (CY 2024). The 963-page proposal, was issued on July 13 and has a 60-day comment period ending September 11.

The proposal is scheduled for publication in the ***Federal Register*** on July 31. A copy is currently available at: https://public-inspection.federalregister.gov/2023-14768.pdf.

The proposed rule also would update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program, the ASC Quality Reporting (ASCQR) Program, and the Rural Emergency Hospital Quality Reporting (REHQR) Program.

In addition, the rule would establish payment for certain intensive outpatient services under Medicare, beginning January 1, 2024

Also, the proposal would update and refine requirements for hospitals to make public their standard charge information and enforcement of hospital price transparency. CMS proposes to revise the personnel qualifications of Mental Health Counselors and add personnel qualifications for Marriage and Family Therapists in the CMHC Conditions of Participation (CoPs). CMS is seeking comment on separate payment under the Inpatient Prospective Payment System (IPPS) for establishing and maintaining access to a buffer stock of essential medicines to foster a more reliable, resilient supply of these medicines.

The Addenda relating to the OPPS are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.

The Addenda relating to the ASC payment system are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASCRegulations-and-Notices.

Comment

CMS notes the policies in this rule will affect approximately 3,500 hospitals and 6,000 ASCs. While CMS has a condensed table of contents, we are adding page numbers (in red) to help readers locate specific items we have addressed.

There are many items in the rule not addressed in this summary and analysis. The material is just too long to cover all.

Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance, at 573-893-3700 | ext. 1336 or awheeler@mhanet.com.

I. SUMMARY of SELECT PROVISIONS (Page 15)

The following is a summary of select items from the regulation's preamble text with appropriate cites to other sections.

OPPS Update: (Page 15) (875)

For 2024, CMS propose to increase the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.8%. This proposed increase factor is based on the proposed inpatient hospital market basket percentage increase of 3% for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a proposed productivity adjustment of 0.2 percentage point.

CMS says that "based on this update, we estimate that total payments to OPPS providers (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case mix) for calendar year (CY) 2024 would be approximately $88.6 billion, an increase of approximately $6.0 billion compared to estimated CY 2023 OPPS payments."

CMS is continuing to implement the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements by applying a reporting factor of 0.9805 to the OPPS payments and copayments for all applicable services.

CMS estimates that "the total change in payments between CY 2023 and CY 2024, considering all budget-neutral payment adjustments, changes in estimated total outlier payments, the application of the frontier State wage adjustment, in addition to the application of the OPD fee schedule increase factor after all adjustments required by sections 1833(t)(3)(F), 1833(t)(3)(G), and 1833(t)(17) of the Act would increase total estimated OPPS payments by 2.9%. (Page 875)

CMS have prepared accounting statements to illustrate the impacts of the OPPS and ASC changes in this proposed rule. (Page 900)

Accounting Statement: CY 2024 Estimated Hospital OPPS Transfers From CY 2023 to CY 2024 Associated with the CY 2024 Hospital Outpatient OPD Fee Schedule Increase

Category	Transfers
Annualized Monetized Transfers	$1,920 million
From Whom to Whom	Federal Government to outpatient hospitals and other providers who receive payment under the hospital OPPS

Accounting Statement: Classification of Estimated Transfers From CY 2023 to CY 2024 as a Result of the Proposed CY 2024 Updated to the ASC Payment System

Category	Transfers
Annualized Monetized Transfers	$130 million
From Whom to Whom	Federal Government to Medicare Providers and Suppliers

Comment

For CY 2023, CMS increased payment rates by a market-basket rate of 4.1%, not reflecting productivity adjustments. This year CMS is proposing and update of 3.0%. While the latest inflation factor is 3.0%, the updates appear to be less than the rates of inflation.

As noted in our analysis on CMS' recent Home Health proposal, CMS estimated inadequately in determining budget neutrality amounts for the change from the 153 category payments system to the Patient-Driven Groupings Model (PDGM). Perhaps it's time for CMS to account for all of its estimations. It would truly be helpful to understand CMS' logic here.

Data used in CY 2023 OPPS/ASC Rate-setting: (Page 16)

CMS proposes to resume its typical data process of using the most updated cost reports and claims data available for CY 2024 OPPS rate setting.

Partial Hospitalization Update: (Page 16) (Page 343)

For CY 2024, CMS proposes changes to its methodology used to calculate the Community Mental Health Center (CMHC) and hospital-based PHP (HB PHP) geometric mean per diem costs, as well as proposing changes to expand PHP payment from two APCs to four APCs.

Proposed Medicare Payment for Intensive Outpatient Programs (Page 16) (Page 343)

Beginning in CY 2024, CMS proposes to establish payment for intensive outpatient programs (IOPs) under Medicare. CMS proposes the scope of benefits, physician certification requirements, coding and billing, and payment rates under the IOP benefit. IOP services may be furnished in hospital outpatient departments, community mental health centers (CMHCs), federally qualified health centers (FQHC), and rural health clinics (RHC). CMS also proposes to establish payment for intensive outpatient services provided by opioid treatment programs (OTPs) under the existing OTP benefit.

Changes to the Inpatient Only (IPO) List: (Page 17) (423)

For 2024, CMS is not proposing to remove any services from the IPO list.

340B–Acquired Drugs (Page 17) (Page 323)

For 2024 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. That is ASP +6.0%.

Device Pass-Through Payment Applications: (Page 17) (Page 185)

For CY 2024, CMS received six applications for device pass-through payments.

Cancer Hospital Payment Adjustment: (Page 18) (Page 97)

CMS is continuing to providing additional payments to 11 cancer hospitals so that a cancer hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data.

CMS proposes to reduce the target PCR by 1.0 percentage point each calendar year until the target PCR equals the PCR of non-cancer hospitals using the most recently submitted or settled cost report data. For CY 2024, CMS proposes to use a target PCR of 0.88 to determine the CY 2024 cancer hospital payment adjustment to be paid at cost report settlement.

ASC Payment Update: (Page 18) (547)

For CY 2024, CMS proposes to increase payment rates under the ASC payment system by 2.8% for ASCs that meet the quality reporting requirements under the ASCQR Program. This increase is based on a hospital market basket percentage increase of 3.0% reduced by a productivity adjustment of 0.2 percentage point. Based on this proposed update, CMS estimates that total payments to ASCs

(including beneficiary cost sharing and estimated changes in enrollment, utilization, and case-mix) for CY 2024 "will be approximately $6.0 billion, an increase of approximately $170 million compared to estimated CY 2023 Medicare payments."

Comment

Something is amiss here. In the accounting table above CMS says the increase for CY 2024 will be $130 million more than 2023. Yet, here CMS says the increase will be $170 million more.

Changes to the List of ASC Covered Surgical Procedures: (Page 18) (Page 515)

CMS proposes to add 26 dental surgical procedures to the ASC covered procedures list (CPL) based upon existing criteria at § 416.166.

Hospital Outpatient Quality Reporting (OQR) Program: (Page 18) (Page 549)

CMS is proposing to: (1) remove the Left Without Being Seen measure beginning with the CY 2024 reporting period/2026 payment determination; (2) modify the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure beginning with the CY 2024 reporting period/CY 2026 payment determination; (3) modify the Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure beginning with the voluntary CY 2024 reporting period; (4) modify the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2024 reporting period/CY 2026 payment determination; (5) re-adopt with modification the Hospital Outpatient Volume Data on Selected Outpatient Procedures measure beginning with the voluntary CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; (6) 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; (7) adopt the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) measure, beginning with the voluntary CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; and (8) amend multiple codified regulations to replace references to "QualityNet" with "CMS-designated information system" or "CMS website," and to make other conforming technical edits, to accommodate recent and future systems requirements and mitigate confusion for program participants.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program: (Page 19) (Page 634)

CMS proposes to: (1) modify the COVID–19 Vaccination Coverage Among Health Care Personnel (HCP) measure beginning with the CY 2024 Reporting Period/CY 2026 payment determination; (2) modify the Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure beginning with the voluntary CY 2024 reporting period; (3) modify the Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2024 reporting period/CY 2026 payment determination; (4) 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; (5) 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; and (6) amend multiple codified regulations to replace references to "QualityNet" with "CMS-designated information system" or "CMS website," and to make other conforming technical edits, to accommodate recent and future systems requirements and mitigate confusion for program participants.

Organ Acquisition Payment Policy: (Page 19)

CMS is finalizing its proposal to exclude research organs from the ratio used to calculate Medicare's share of organ acquisition costs and a is modifying the requirement to offset costs by allowing providers to follow their accounting practices of adjusting costs, offsetting revenue or establishing a non-reimbursable cost center, which will maintain or lower the cost of procuring and providing research organs to the research community. Finally, CMS is finalizing its proposal to cover as organ acquisition costs certain hospital services provided to donors whose death is imminent, to promote organ procurement and enhance equity.

Rural Emergency Hospital (REH) Payment Polices: (Page 20)

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.

Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes (Page 21)

CMS proposes technical refinements to the existing coding for remote mental health services to allow for multiple units to be billed daily. CMS also proposes to create a new, untimed code to describe group psychotherapy. Finally, CMS proposes to delay any in-person visit requirements until the end of CY 2024.

Proposed OPPS Payment for Dental Services (Page 21)

CMS is proposing to assign 229 HCPCS codes describing dental services to various clinical APCs to align with Medicare payment provisions regarding dental services in the CY 2023 PFS final rule.

Supervision by Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists of Cardiac, Intensive Cardiac and Pulmonary Rehabilitation Services Furnished to Outpatients (Page 21)

CMS proposes to revise § 410.27(a)(1)(iv)(B)(1) to expand the practitioners who may supervise cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR) services to include nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs). CMS also proposes to allow for the direct supervision requirement for CR, ICR, and PR to include virtual presence of the physician through audio-video real-time communications technology (excluding audio-only) through December 31, 2024 and extend this policy to the nonphysician practitioners, that is NPs, PAs, and CNSs, who are eligible to supervise these services in CY 2024.

CMS proposes to pay for ICR services furnished by an off-campus, non-excepted Provider Based Department (PBD) of a hospital at 100% of the OPPS rate, which is the amount paid for these services under the PFS.

II. UPDATES AFFECTING OPPS PAYMENTS (Page 34)

A. Recalibration of APC Relative Payment Weights (Page 34)

Proposed Calculation of Single Procedure APC Criteria-Based Costs

- *Blood and Blood Products* (Page 40)

  CMS will continue to establish payment rates for blood and blood products using its blood-specific CCR methodology. Addendum B contains the proposed CY 2024 payment rates for blood and blood products at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.

- *Brachytherapy Sources* (Page 42)

  CMS proposes to designate five brachytherapy APCs as Low Volume APCs.

  The final CY 2023 payment rates for brachytherapy sources are included in Addendum *B*

Comprehensive APCs (C-APCs) for CY 2024 (Page 49)

A C-APC is defined as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service.

A list of services excluded from the C-APC policy is included in Addendum J at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices. (Page 47)

CMS is creating two new APCs that will both be C-APCs. Thus, the number of C-APCs for CY 2024 would be 72 C-APCs. (Page 58)

The rule's Table 1 lists the proposed C-APCs for CY 2024. (Page 59)

Calculation of Composite APC Criteria-Based Costs

- *Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)* (Page 64) The rule's Table 2 (Page 66) lists the HCPCS codes that will be subject to the multiple imaging composite APC policy and their respective families and approximate composite APC proposed geometric mean costs for CY 2024.

B. Proposed Conversion Factor (CF) (Page 82)

For 2024, CMS proposes to use a conversion factor of $87.488 as calculated below. (Page 87)

Calculation of CY 2024 Proposed OPPS Conversion Factor

Start:	CY 2023 Final OPPS Conversion Factor = **$85.585**
Step 1a:	Adjust the conversion factor to temporarily account for additional drug and device pass-through spending and outlier spending in CY 2023. This action causes an increase in the conversion factor. So, the amount of both drug and device pass-through spending (0.0016) and the percentage of outlier spending (0.01). as a share of total OPPS outpatient hospital spending is subtracted from 1.0000, which represents total OPPS outpatient hospital spending for CY 2023. ➢ 1.0000– (0.0016+0.01) = 0.9884
Step 1b:	Divide $85.585 by 0.9884 ➢ $85.585/0.9884 = **$86.589**
Step 2:	Adjust the conversion factor by the required wage index budget neutrality adjustment of approximately 0.9974. This adjustment reduces the amount of OPPS outpatient hospital spending and is multiplied with $86.589. ➢ $86.589*0.9974 = **$86.364**
Step 3:	Adjust the conversion factor by the proposed 5% annual cap for individual hospital wage index reductions adjustment of approximately 0.9975. This adjustment reduces the amount of outpatient hospital spending and is multiplied with $86.364. ➢ $86.364*0.9975 = **$86.148**
Step 4:	Adjust the conversion factor by the proposed cancer hospital payment adjustment of 1.0005. Because the PCR for cancer hospitals is declining between CY 2023 and CY 2024, it increases the amount of outpatient hospital spending for providers that are not cancer hospitals and is multiplied with $86.148. ➢ $86.148*1.0005 = **$86.191**
Step 5:	Adjust the conversion factor by rural SCH adjustment policy of 1.0000. Since CMS is proposing to maintain its current policy, there is no impact on the conversion by this policy. ➢ $86.191*1.0000 = **$86.191**
Step 6a:	Adjust the conversion factor by the proposed OPD fee schedule increase factor of 0.028 for CY 2024. The proposed OPD fee schedule increase factor increases outpatient hospital spending in CY 2024 over CY 2023 and is added to 1.0000 which represents total outpatient hospital OPPS spending in CY 2023. ➢ 1.0000+0.028 = 1.0280
Step 6b:	Multiply $86.191 by 1.0280. ➢ $86.191*1.0280 = **$88.605**

Step 7a:	Adjust the conversion factor to remove additional drug and device pass-through spending and outlier spending for CY 2024. This action causes a decrease in the conversion factor. So, the amount of both drug and device pass-through spending (0.0026) and the percentage of outlier spending (0.01) as a share of total OPPS outpatient hospital spending is subtracted from 1.0000, which represents total OPPS outpatient hospital spending for CY 2024. ➢ 1.0000– (0.0026+0.01) = 0.9874
Step 7b:	Multiply $88.605 by 0.9874 to get the CY 2024 proposed OPPS conversion factor. ➢ $88.605/0.9874 = **$87.488**
Finish:	**CY 2024 Proposed OPPS Conversion Factor = $87.488**

C. Proposed Wage Index Changes (Page 88)

The OPPS labor-related share remains at 60% of the national OPPS payment.

Addendum L at: https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/index, readers is a link to the proposed FY 2024 IPPS wage index tables.

D. Proposed Statewide Average Default CCRs (Page 95)

CMS will calculate the default ratios for CY 2024 using the June 2020 HCRIS cost reports.

E. Proposed Adjustment for Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) under Section 1833(t)(13)(B) of the Act for CY 2023 (Page 96)

For CY 2024, CMS will continue the current policy of a 7.1% payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, items paid at charges reduced to costs, and devices paid under the pass-through payment policy, applied in a budget neutral manner.

F. Proposed Payment Adjustment for Certain Cancer Hospitals for CY 2024 (Page 97)

The rule's Table 5 has the estimated percentage increase in OPPS payments to each of the 11 eligible cancer hospital for CY 2024. (Page 103)

G. Proposed Hospital Outpatient Outlier Payments (Page 105)

Using CY 2022 claims data and CY 2023 payment rates, CMS estimates that the aggregate outlier payments for CY 2023 would be approximately 0.78% of the total CY 2023 OPPS payments.

CMS says that to ensure that the estimated CY 2024 aggregate outlier payments would equal 1.0% of estimated aggregate total payments under the OPPS, CMS proposes that the hospital outlier threshold be set so that outlier payments would be triggered when a hospital's cost of furnishing a service exceeds 1.75 times the APC payment amount and exceeds the APC payment amount plus **$8,350.**

The current payment amount is $8,625.

For CMHCs, the threshold would be 3.40 times the payment rate, and the outlier payment will be calculated as 50% of the amount by which the cost exceeds 3.40 times.

H. Calculation of an Adjusted Medicare Payment from the National Unadjusted Medicare Payment (Page 108)

The national unadjusted payment rate is the is the payment rate for most APC's before accounting for the wage index adjustment or any applicable adjustments.

The national unadjusted payment rates are contained in Addendum A at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.

III. PROPOSED OPPS AMBULATORY PAYMENT CLASSIFICATION (APC) GROUP POLICIES (Page 121)

A. OPPS Treatment of New CPT and Level II HCPCS Codes

CMS recognizes the following codes on OPPS claims:

- Category I CPT codes, which describe surgical procedures, diagnostic and therapeutic services, and vaccine codes;
- Category III CPT codes, which describe new and emerging technologies, services, and procedures;
- MAAA CPT codes, which describe laboratory multianalyte assays with algorithmic analyses (MAA);
- PLA CPT codes, which describe proprietary laboratory analyses (PLA) services; and
- Level II HCPCS codes (also known as alpha-numeric codes), which are used primarily to identify drugs, devices, supplies, temporary procedures, and services not described by CPT codes.

The following reflects CMS' treatment of new codes added during the year.

1. *April 2023 HCPCS Codes*

   For the April 2023 update, 67 new HCPCS codes were established and made effective on April 1, 2023. These codes and their long descriptors are listed in the rules' Table 6. (Page 124)

2. *July 2023 HCPCS Codes*

   For the July 2023 update, 97 new codes were established and made effective July 1, 2023. The codes and long descriptors are listed in the rule's Table 7. (Page 128)

3. *October 2023 HCPCS Codes* (Page 132)

   CMS will solicit comments on the new CPT and Level II HCPCS codes that will be effective October 1, 2023, in the CY 2024 OPPS/ASC final rule.

4. *January 2023 HCPCS Codes* (Page 133)

For CY 2024, CMS proposes to continue its established policy of assigning comment indicator "NI" in Addendum B to the OPPS/ASC final rule to the new HCPCS codes that will be effective January 1, 2024, to indicate that CMS is assigning them an interim status indicator, which is subject to public comment.

B. Proposed OPPS Changes – Variations within APCs (Page 136)

The Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost for an item or service in the group is more than 2 times greater than the lowest cost for an item or service within the same group (referred to as the "2 times rule"). The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low volume items and services.

The rule's Table 9 lists 21 APCs that CMS is proposing to exempt from the 2 times rule for CY 2024. (Page 153)

C. Proposed New Technology APCs (Page 142)

The procedures proposed to be assigned to New Technology APCs are listed below. None have been approved, so far. CMS is seeking comments.

a. Administration of Subretinal Therapies Requiring Vitrectomy (APC 1563) (Page 146)
b. Bronchoscopy with Transbronchial Ablation of Lesion(s) by Microwave Energy (APC 1562) (Page 150)
c. Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies (APCs 1518, 1521, and 1522) (Page 152)
d. V-Wave Medical Interatrial Shunt Procedure (APC 1590) (Page 155)
e. Corvia Medical Interatrial Shunt Procedure (APC 1592) (Page 157)
f. Supervised Visits for Esketamine Self-Administration (APCs 1513 and 1518) (Page 158)
g. DARI Motion Procedure (APC 1505) (Page 161)
h. Liver Histotripsy Service (APC 1575) (Page 162)
i. Liver Multiscan Service (APC 1505) (Page 164)
j. Minimally Invasive Glaucoma Surgery (MIGS) (APC 5493) (Page 167)
k. Scalp Cooling (APC 1514) (Page 170)
l. Optellem Lung Cancer Prediction (LCP) (APC 1508) (Page 172)
m. Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP) (APC 1511) (Page 173)
n. CardiAMP (APC 1590) (Page 175)
o. Surfacer® Inside-Out® Access Catheter System (APC 1534) (Page 177)
p. Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (APC 1580) (Page 177)
q. Cleerly Labs (APC 1511) (Page 179)

D. Universal Low Volume APC Policy for Clinical and Brachytherapy APCs (Page 182)

CMS proposes to designate five brachytherapy APCs and five clinical APCs as low volume APCs under the OPPS.

The rule's Table 27 includes the APC geometric mean cost without the low volume APC designation, that is, if CMS calculated the geometric mean cost based on CY 2022 claims data available for rate setting; the median, arithmetic mean, and geometric mean cost using up to four years of claims data based on

the APC's designation as a low volume APC; and the statistical methodology CMS proposes to use to determine the APC's cost for rate setting purposes for CY 2024.

E. Proposed APC-Specific Policies: Intraocular Procedures (Page 184)

CMS proposes to establish a six-level APC structure for the Intraocular Procedures series.

IV. OPPS PAYMENT FOR DEVICES (Page 185)

A. Proposed Pass-Through Payment for Devices

The intent of transitional device pass-through payment, as implemented at § 419.66, is to facilitate access for beneficiaries to the advantages of new and truly innovative devices by allowing for adequate payment for these new devices while the necessary cost data is collected to incorporate the costs for these devices into the procedure APC rate.

1. *Expiration of Transitional Pass-Through Payments for Certain Devices (Page 187)*

   Currently, there are 15 device categories eligible for pass-through payment. These devices are listed in Table 28. (Page 188)

2. *New Device Pass-Through Applications* (Page 189)

CMS says it received "six" complete applications by the March 1, 2023 quarterly deadline. (Page 192)

1. Two are based on the Alternative Pathway Device Pass-through Applications:

   (1) CavaClear Inferior Vena Cava (IVC) Filter Removal Laser Sheath (Page 193)

   (2) CERAMENT® G (Page 199)

2. Four are based on the Traditional Device Pass-through Applications (Page 209)

   (1) Ambu® aScopeTM 5 Broncho HD (Page 209)

   (2) Praxis Medical CytoCore (Page 228)

   (3) EchoTip® (Page 241)

   (4) *FLEX Vessel Prep™ System* (Page 251)

B. Proposed Device-Intensive Procedures (Page 262)

The full listing of the proposed CY 2024 device-intensive procedures can be found in Addendum P to this proposed rule. (Page 269)

V. *PROPOSED OPPS PAYMENT FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS* (Page 275)

A. Proposed Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals

1. Drugs and Biologicals with Expiring Pass-Through Payment Status in CY 2023 (Page 278)

There are 43 drugs and biologicals for which pass-through payment status expires by December 31, 2023, as listed in the rule's Table 35. (Page 279)

2. Proposed Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Expiring in CY 2024. (Page 282)

CMS proposes to end pass-through payment status in CY 2024 for 25 drugs and biologicals. These drugs and biologicals, which were initially approved for pass-through payment status between April 1, 2021, and January 1, 2022, are listed in the rule's Table 36.

3. Proposed Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Continuing through CY 2024. (Page 287)

CMS proposes to continue pass-through payment status in CY 2024 for 42 drugs and biologicals. These drugs and biologicals, which were approved for pass-through payment status with effective dates beginning between April 1, 2022, and April 1, 2023, are listed in the rule's Table 37. (Page 289)

B. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Payment Status (Page 295)

1. Proposed Packaging Threshold. (Page 295)

The packaging threshold for CY 2024 is being proposed at **$140.** The current amount is $135. The amount for CY 2022 was $130.

2. Packaging of Payment for HCPCS Codes that Describe Certain Drugs, Certain Biologicals, and Certain Therapeutic Radiopharmaceuticals Under the Cost Threshold ("Threshold-Packaged Drugs." (Page 296)

For CY 2024 CMS proposes to use payment rates based on the ASP data from the fourth quarter of CY 2022 for budget neutrality estimates, packaging determinations, impact analyses, and completion of Addenda A and B because these are the most recent data available for use at the time of development of the CY 2024 OPPS/ASC proposed rule. These data also were the basis for drug payments in the physician's office setting, effective April 1, 2023. For items that did not have an ASP-based payment rate, such as some therapeutic radiopharmaceuticals, CMS used their mean unit cost derived from the CY 2022 hospital claims data to determine their per day cost. (Page 297)

3. Packaging Determination for HCPCS Codes that Describe the Same Drug or Biological but Different Dosages. (Page 300)

For CY 2024, in order to propose a packaging determination that is consistent across all HCPCS codes that describe different dosages of the same drug or biological, CMS aggregated both its CY 2022 claims data and pricing information, which is based on the ASP methodology, which is generally ASP plus 6 percent, across all of the HCPCS codes that describe each distinct drug or biological in order to determine the mean units per day of the drug or biological in terms of the HCPCS code with the lowest dosage descriptor.

The proposed packaging status of each drug and biological HCPCS code to which this methodology would apply in CY 2024 is displayed in the rule's Table 39. (Page 302)

4. Provisions of the Inflation Reduction Act Relating to Biologicals (Page 308)

The ***Inflation Reduction Act of 2022*** (IRA) requires a temporary increase in the add-on payment for qualifying biosimilar biological products from 6% to 8% of the ASP of the reference biological beginning October 1, 2022. This increase applies for a 5-year period.

For existing qualifying biosimilars for which payment was made using ASP as of September 30, 2022, the 5-year period began on October 1, 2022. For new qualifying biosimilars for which payment is first made using ASP between October 1, 2022, and December 31, 2027, the applicable 5-year period begins on the first day of the calendar quarter during which such payment is made.

Payment for Blood Clotting Factors (Page 315)

The furnishing fee for blood clotting factors under the OPPS is consistent with the methodology applied in the physician's office and in the inpatient hospital setting.

CMS says that "in accordance with our policy as finalized in the CY 2008 OPPS/ASC final rule, we will announce the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure through applicable program instructions and posting on our website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html."

Proposed OPPS Payment Methodology for 340B Purchased Drugs and Biologicals (Page 318)

CMS is proposing that all 340B covered entity hospitals paid under the OPPS would report the "TB" modifier effective January 1, 2025, even if the hospital previously reported the "JG" modifier.

The "JG" modifier would remain effective through December 31, 2024. Hospitals that currently report the "JG" modifier could choose to continue to use it in CY 2024 or choose to transition to use of the "TB" modifier during that year. Beginning on January 1, 2025, the "JG" modifier would be deleted and hospitals would be required to report drugs and biologicals acquired through the 340B program using the "TB" modifier. (Page 323)

High Cost/Low-Cost Threshold for Packaged Skin Substitutes (Page 323)

Skin substitutes assigned to the high-cost group are described by HCPCS codes 15271 through 15278. Skin substitutes assigned to the low-cost group are described by HCPCS codes C5271 through C5278.

The proposed CY 2024 mean unit cost (MUC) threshold is $47 per cm2 (rounded to the nearest $1) and the proposed CY 2024 per day cost (PDC) threshold is $817 (rounded to the nearest $1). (Page 325)

The rule's Table 41 includes the proposed CY 2024 cost category assignment for each skin substitute product. (Page 328)

VI. PROPOSED ESTIMATE OF OPPS TRANSITIONAL PASS-THROUGH SPENDING FOR DRUGS, BIOLOGICALS, RADIOPHARMACEUTICALS, AND DEVICES (Page 336)

CMS estimates that the amount of pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2024 and those device categories, drugs, and biologicals that first become eligible for pass-through payment during CY 2024 would be approximately $234.1 million (approximately $134.1 million for device categories and approximately $100 million for drugs and biologicals) which represents 0.26% of total projected OPPS payments for CY 2024 (approximately $88.6 billion). Therefore, CMS estimates that pass-through spending in CY 2024 would not amount to 2.0% of total projected OPPS CY 2024 program spending. (Page 342)

VII. PROPOSED OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS AND CRITICAL CARE SERVICES (Page 343)

CMS will continue to utilize a Physician Fee Schedule (PFS)-equivalent payment rate for hospital outpatient clinic visit services described by HCPCS code G0463 when it is furnished by excepted off-campus provider-based departments. The PFS-equivalent rate for CY 2024 would be 40% of the OPPS payment (that is, 60% less than the OPPS rate).

VIII. PAYMENT FOR PARTIAL HOSPITALIZATION SERVICES AND INTENSIVE OUTPATIENT SERVICES (Page 343)

A partial hospitalization program (PHP) is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorders.

Section 4124(b) of the ***Consolidated Appropriations Act*** *(*CAA) 2023 established Medicare coverage for intensive outpatient services effective for items and services furnished on or after January 1, 2024. (Page 350)

CMS is proposing to establish an Intensive Outpatient Program (IOP) under Medicare. The proposed rule includes the scope of benefits, physician certification requirements, coding and billing, and payment rates under the IOP benefit. IOP services may be furnished in hospital outpatient departments, Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs), if finalized.

Similar to PHP, an IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorders. Generally speaking, an IOP is thought to be less intensive than a PHP. (Page 350)

Intensive outpatient program services are not intended for those who otherwise need an inpatient level of care. (Page 353)

CMS proposes to require hospitals and CMHCs to report condition code 92 on claims to indicate that a claim is for intensive outpatient services. CMS proposes to continue to require hospitals to report condition code 41 for partial hospitalization claims. (Page 362)

For reference, Table 42 includes the current list of HCPCS codes that are recognized for PHP payment. For CY 2024, CMS proposes to add certain codes to the list, change the descriptions of other codes, and remove one code from the list. The list of proposed consolidated HCPCS codes is included in Table 43. (Page 363)

CMS proposes to add 18 codes to the list of recognized PHP/IOP codes in Table 43. Specifically, CMS proposes that to qualify for payment for the IOP APC (5851, 5852, 5861 or 5862) or the PHP APC (5853, 5854, 5863, or 5864) one service must be from the Partial Hospitalization and Intensive Outpatient Primary list. Table 44. (Page 367)

Proposed Payment Rate Methodology for PHP and IOP (Page 371)

CMS is proposing to establish four separate PHP APC per diem payment rates: one for CMHCs for 3-service days and another for CMHCs for 4-service days (APC 5853 and APC 5854, respectively), and one for hospital-based PHPs for 3-service days and another for hospital-based PHPs for 4-service days (APC 5863 and APC 5864, respectively).

The proposed CY 2024 PHP geometric mean per diem costs are shown in Table 45 and are used to derive the proposed CY 2024 PHP APC per diem rates for CMHCs and hospital-based PHPs. CMS proposes to use the same 3-service day and 4-service day geometric mean per diem PHP costs for the CY 2024 CMHC and hospital-based IOP APCs. The proposed CY 2024 PHP and IOP APC per diem rates are included in Addendum A. (Page 381)

Table 45 Proposed CY 2024 PHP and IOP APC Geometric Mean Per Diem Costs

CY 2024 APC	Group Title	Proposed PHP and IOP APC Geometric Mean Per Diem Costs
5851	Intensive Outpatient (3 services per day) for CMHCs	$97.59
5852	Intensive Outpatient (4 or more services per day) for CMHCs	$153.09
5853	Partial Hospitalization (3 services per day) for CMHCs	$97.59
5854	Partial Hospitalization (4 or more services per day) for CMHCs	$153.09
5861	Intensive Outpatient (3 services per day) for hospital-based IOPs	$284.00
5862	Intensive Outpatient (4 or more services per day) for hospital-based IOPs	$368.18
5863	Partial Hospitalization (3 services per day) for hospital-based PHPs	$284.00
5864	Partial Hospitalization (4 or more services per day) for hospital-based PHPs	$368.18

Table 46: Alternative CY 2024 PHP and IOP APC Geometric Mean Per Diem Costs

Group Title	Alternative PHP and IOP APC Geometric Mean Per Diem Costs
Partial Hospitalization (three services per day)	$281.48

Group Title	Alternative PHP and IOP APC Geometric Mean Per Diem Costs
Partial Hospitalization (four services per day)	$316.63
Intensive Outpatient (three services per day)	$281.48
Intensive Outpatient (four services per day)	$316.63

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (Page 403)

CMS is proposing to establish payment under Part B for IOP services furnished by OTPs for the treatment of OUD for CY 2024 and subsequent years. (Page 410)

OTP intensive outpatient services are services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition; are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization; and are furnished in accordance with a physician certification and plan of care. CMS proposes that in order to qualify as "OTP intensive outpatient services," a physician must certify that the individual has a need for such services for a minimum of 9 hours per week and requires a higher level of care intensity compared to existing OTP services.

Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital (Page 421)

CMS says it is considering whether it would be appropriate to apply a different methodology for calculating the PHP and IOP rates for nonexcepted off-campus hospital outpatient departments and is soliciting comments on alternative methodologies commenters believe would be appropriate.

IX. SERVICES THAT WILL BE PAID ONLY AS INPATIENT SERVICES (Page 423)

CMS is are not proposing to remove any services from the IPO list for CY 2024.

However, CMS is proposing to add nine services for which codes were newly created by the AMA CPT Editorial Panel for CY 2024 to the IPO list. These new services are described by the placeholder CPT codes X114T, 2X002, 2X003, 2X004, 619X1, 7X000, 7X001, 7X002, and 7X003, which will be effective on January 1, 2024.

The CPT codes, long descriptors, and the proposed CY 2024 payment indicators are displayed in the rule's Table 47.

X. NONRECURRING POLICY CHANGES (Page 428)

CMS addresses the following non-recurring policy changes as noted below.

A. Supervision by Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists of Cardiac Rehabilitation, Intensive Cardiac Rehabilitation, and Pulmonary Rehabilitation Services Furnished to Hospital Outpatients (Page 428)
B. Payment for Intensive Cardiac Rehabilitation Services (ICR) Provided by an Off-Campus, Non-Excepted Provider Based Department (PBD) of a Hospital (Page 431)

C. OPPS Payment for Specimen Collection for COVID–19 Tests (Page 436)
D. Remote Services (Page 438)
E. OPPS Payment for Dental Services (Page 442)
F. Use of Claims and Cost Report Data for CY 2024 OPPS and ASC Payment System Rate Setting Due to the PHE (Page 457)

XI. PROPOSED CY 2024 OPPS PAYMENT STATUS AND COMMENT INDICATORS (Page 463)

For CY 2024, CMS proposes to change the definition of status indicator "P" from "Partial Hospitalization" to "Partial Hospitalization or Intensive Outpatient Program" in order to account for the proposed payment of intensive outpatient services beginning January 1, 2024.

CMS is not proposing to make any other changes to the existing definitions of status indicators that were listed in Addendum D1 to the CY 2023 OPPS/ASC final rule. The complete list of proposed CY 2024 payment status indicators and their definitions is displayed in proposed Addendum D1.

Proposed CY 2024 Comment Indicator Definitions (Page 465)

CMS is proposing to use four comment indicators for the CY 2024 OPPS. These comment indicators, "CH," "NC," "NI," and "NP," are in effect for CY 2023; and CMS is proposing to continue their use in CY 2024. The proposed CY 2024 OPPS comment indicators are as follows:

- "CH"—Active HCPCS code in current and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that will be discontinued at the end of the current calendar year.
- "NC"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, as compared to current calendar year for which CMS requested comments in the proposed rule, final APC assignment; comments will not be accepted on the final APC assignment for the new code.
- "NI"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.
- "NP"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, as compared to current calendar year, proposed APC assignment; comments will be accepted on the proposed APC assignment for the new code.

The definitions of the proposed OPPS comment indicators for CY 2024 are listed in Addendum D2 to this proposed rule.

XII MEDPAC RECOMMENDATIONS (Page 465)

Not addressed inasmuch as this section is basically informational and does not impact this proposed rule.

XIII. PROPOSED UPDATES TO THE AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM (Page 467)

A. Proposed Calculation of the ASC Payment Rates and the ASC Conversion Factor (Page 902)

For CY 2024, CMS proposes to adjust the CY 2023 ASC conversion factor ($51.854) by the proposed wage index budget neutrality factor of 1.0017 in addition to the productivity-adjusted hospital market basket update of 2.8% discussed above, which results in a proposed CY 2024 ASC conversion factor of **$53.397** for ASCs meeting the quality reporting requirements. (Page 547)

For ASCs not meeting the quality reporting requirements, CMS adjusts the CY 2023 ASC conversion factor ($51.854) by the wage index budget neutrality factor of 1.0017 in addition to the non-reporting/productivity-adjusted hospital market basket update of 0.8% (2.8-2.0), which results in a CY 2024 ASC conversion factor of **$52.358.** (Page 547)

Addenda AA and BB reflect the full ASC payment updates and not the reduced payment update used to calculate payment rates for ASCs not meeting the quality reporting requirements under the ASCQR Program.

B. Proposed ASC Treatment of New and Revised Codes (Page 468)

1. April 2023 HCPCS Codes (Page 470)

For the April 2023 update, there were no new CPT codes; however, there were several new Level II HCPCS codes.

The rule's Table 54 lists the new Level II HCPCS codes implemented April 1, 2023, along with their payment indicators for CY 2024.

2. July 2023 HCPCS Codes Proposed Rule Comment Solicitation (Page 472)

Table 55 (New HCPCS Codes for Covered Surgical Procedures and Covered Ancillary Services Effective July 1, 2023) lists the new HCPCS codes that are effective July 1, 2023.

3. October 2023 HCPCS Codes Final Rule Comment Solicitation (Page 474)

For CY 2024, consistent with CMS' established policy, the agency proposes that the Level II HCPCS codes that will be effective October 1, 2023, would be flagged with comment indicator "NI" in Addendum BB to the CY 2024 OPPS/ASC final rule with comment period to indicate that they have assigned codes on an interim ASC payment status for CY 2023..

4. January 2024 HCPCS Codes (Page 475)

Because these codes are not available until November, CMS says it is unable to include them in the OPPS/ASC proposed rules. Therefore, these Level II HCPCS codes will be released to the public through

the CY 2024 OPPS/ASC final rule with comment period, January 2024 ASC Update CR, and the CMS HCPCS website.

C. Payment Policies Under the ASC Payment System (Page 480)

CMS proposes that payment for office-based procedures would be at the lesser of the proposed CY 2024 MPFS non-facility PE RVU-based amount or the proposed CY 2024 ASC payment amount calculated according to the ASC standard rate setting methodology**.** (Page 482)

CY 2023 ASC Special Payment Policy for OPPS Complexity-Adjusted C-APCs (Page 485)

For CY 2024, CMS is proposing to continue the special payment policy and methodology for OPPS complexity-adjusted C-APCs that was finalized in the CY 2023 OPPS/ASC final rule.

The full list of the proposed ASC complexity adjustment codes for CY 2024 can be found in the ASC addenda and the supplemental policy file, which also includes both the existing ASC complexity adjustment codes and proposed additions, is published with the proposed rule.

Because the complexity adjustment assignments change each year under the OPPS, the proposed list of ASC complexity adjustment codes eligible for this proposed payment policy has changed slightly from the previous year. (Page 490)

Proposed Low Volume APCs and Limit on ASC Payment Rates for Procedures Assigned to Low Volume APCs (Page 491)

CMS proposes to designate four clinical APCs and five brachytherapy APCs as Low Volume APCs. The four clinical APCs and five brachytherapy APCs are shown in the rule's Table 57. (Page 492)

Device-Intensive ASC Covered Surgical Procedures (Page 503)

CMS is not proposing any changes related to designating surgical procedures as device intensive under the ASC payment system for CY 2024. (Page 506)

Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices (Page 506)

"We are not proposing any changes to our policies related to no/cost full credit or partial credit devices for CY 2024." (Page 509)

D. Proposed Additions to ASC Covered Surgical Procedures and Covered Ancillary Services Lists (Page 510)

CMS is proposing to update the ASC CPL by adding 26 dental surgical procedures to the list for CY 2024, as shown in the rule's Table 61. (Page 515)

E. ASC Payment Policy for Non-Opioid Post-Surgery Pain Management Drugs, Biologicals, and Devices *(Page 5*18)

The rule's table 63 lists the four drugs that CMS proposes as eligible to receive separate payment as a non-opioid pain management drug that functions as a supply in a surgical procedure under the ASC payment system for CY 2024. (Page 528)

F. Proposed New Technology Intraocular Lenses (NTIOLs) (Page 898)

CMS did not receive any request for review to establish a new NTIOL class for CY 2024. CMS did not revise the payment adjustment amount for CY 2023.

The current payment adjustment for a five-year period from the implementation date of a new NTIOL class is $50 per lens. This amount has not changed since 1999.

XIV REQUIREMENTS FOR THE HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM (Page 549)

Proposed Removal of the Left Without Being Seen Measure Beginning with the CY 2024 Hospital OQR Reporting Period (Page 550)

CMS proposes to remove the LWBS measure from the program beginning with the CY 2024 reporting period/CY 2026 payment determination. (Page 552)

Modifications to Previously Adopted Measures (Page 552)

CMS proposes to modify three previously adopted measures beginning with CY 2024 reporting period/CY 2026 payment determination: (1) COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure; (2) Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure; and (3) Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure.

Proposed Modification of Survey Instrument Use for the Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery Measure Beginning with the Voluntary CY 2024 Reporting Period (Page 560)

CMS proposes to limit the allowable survey instruments that an HOPD may use to assess changes in patient's visual function for the purposes of the Cataracts Visual Function measure to those listed below:

- The National Eye Institute Visual Function Questionnaire-25 (NEI VFQ-25)
- The Visual Functioning Patient Questionnaire (VF-14)
- The Visual Functioning Index Patient Questionnaire (VF-8R)

Proposed Adoption of New Measures for the Hospital OQR Program Measure Set (Page 570)

CMS is proposing to: (1) re-adopt the original Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures with modification, beginning with the voluntary CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; (2) 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 followed by mandatory reporting beginning with the CY 2027 reporting period/CY 2030 payment determination; and (3) adopt the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults measure, beginning with the voluntary CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.

Previously Finalized and Proposed Hospital OQR Program Measure Sets (Page 598)

Table 66 (below) summarizes the previously finalized and newly proposed Hospital OQR Program measures beginning with the CY 2026 payment determination and subsequent years.

Proposed Hospital OQR Program Measure Set for the CY 2026 Payment Determination and Subsequent Years

CBE #	Measure Name
0514	MRI Lumbar Spine for Low Back Pain†
None	Abdomen CT – Use of Contrast Material
0669	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
0496	Median Time for Discharged ED Patients (Previously referred to as Median Time from ED Arrival to ED Departure for Discharged ED Patients)
0661	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
None	HOPD Procedure Volume (Previously referred to as Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures)*
0658	Colonoscopy Follow-Up Interval (Previously referred to as Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients)
1536	Cataracts Visual Function (Previously referred to as Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery)**
2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
3490	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	Hospital Visits after Hospital Outpatient Surgery
None	OAS CAHPS – About Facilities and Staff
None	OAS CAHPS – Communication About Procedure
None	OAS CAHPS – Preparation for Discharge and Recovery
None	OAS CAHPS – Overall Rating of Facility
None	OAS CAHPS – Recommendation of Facility
3636	COVID–19 Vaccination Coverage Among Health Care Personnel
None	Breast Cancer Screening Recall Rates
None	ST-Segment Elevation Myocardial Infarction (STEMI) eCQM
None	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)
3663e	Excessive Radiation eCQM (Previously referred to as Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults eCQM)****

† CMS notes that CBE endorsement for this measure was removed.
* In this proposed rule, CMS proposes a measure modification to Colonoscopy Follow-Up Interval beginning with the CY 2024 reporting period/CY 2026 payment determination.
** In the CY 2023 OPPS/ASC final rule CMS finalized keeping data collection and submission voluntary for the Cataracts Visual Function measure for the CY 2025 reporting period and subsequent years. In this proposed rule, CMS proposes to standardize the surveys offered to patients pre- and post-surgery beginning with the CY 2024 reporting period.
*** In the CY 2022 OPPS/ASC final rule, CMS finalized voluntary reporting beginning with the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/CY 2026 payment determination.
**** In this proposed rule, CMS proposes a measure modification to COVID-19 Vaccination Coverage Among HCP beginning with the CY 2024 reporting period/CY 2026 payment determination.
***** The STEMI eCQM was adopted in the CY 2022 OPPS/ASC final rule beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/CY 2026 payment determination.

Table 67 (below) summarizes the previously finalized and newly proposed Hospital OQR Program measures beginning with the CY 2027 payment determination and subsequent years.

Proposed Hospital OQR Program Measure Set for the CY 2027 Payment Determination and Subsequent Years

CBE #	Measure Name
0514	MRI Lumbar Spine for Low Back Pain†
None	Abdomen CT – Use of Contrast Material
0669	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
0496	Median Time for Discharged ED Patients (Previously referred to as Median Time from ED Arrival to ED Departure for Discharged ED Patients)
0661	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
None	HOPD Procedure Volume (Previously referred to as Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures)*
0658	Colonoscopy Follow-Up Interval (Previously referred to as Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients)
1536	Cataracts Visual Function (Previously referred to as Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery)**
2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
3490	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	Hospital Visits after Hospital Outpatient Surgery
None	OAS CAHPS – About Facilities and Staff
None	OAS CAHPS – Communication About Procedure
None	OAS CAHPS – Preparation for Discharge and Recovery
None	OAS CAHPS – Overall Rating of Facility
None	OAS CAHPS – Recommendation of Facility
3636	COVID–19 Vaccination Coverage Among Health Care Personnel
None	Breast Cancer Screening Recall Rates
None	ST-Segment Elevation Myocardial Infarction (STEMI) eCQM
None	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)
3663e	Excessive Radiation eCQM (Previously referred to as Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults eCQM)****

† CMS notes that CBE endorsement for this measure was removed.
** CMS proposes to re-adopt the HOPD Procedure Volume measure with modification beginning with the voluntary CY 2025 reporting period and mandatory beginning with the CY 2026 reporting period/CY 2028 payment determination.*
*** In the CY 2023 OPPS/ASC final rule with comment period CMS finalized keeping data collection and submission voluntary for this measure for the CY 2025 reporting period and subsequent years.*
****CMS proposes to adopt the THA/TKA PRO–PM beginning with voluntary CYs 2025 and 2026 reporting periods and mandatory beginning with the CY 2027 reporting period/CY 2030 payment determination.*
*****In this proposed rule, CMS proposes to adopt the Excessive Radiation eCQM beginning with the voluntary CY 2025 reporting period and mandatory beginning with the CY 2026 reporting period/CY 2028 payment determination.*

XV. REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM (Page 634)

Modifications to Previously Adopted Measures (Page 637)

CMS is proposing to modify three previously adopted measures beginning with the CY 2024 reporting period/CY 2026 payment determination: (1) COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure; (2) Cataracts: Improvement in Patient's Visual Function Within 90 Days

Following Cataract Surgery measure survey instrument use; and (3) Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure.

Proposed Adoption of New Measures for the ASCQR Program Measure Set (Page 655)

CMS proposes to: (1) re-adopt with modification the ASC Facility Volume Data on Selected ASC Surgical Procedures measure, with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; and (2) 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), with voluntary reporting beginning with the CYs 2025 and 2026 reporting periods followed by mandatory reporting beginning with the CY 2027 reporting period/CY 2030 payment determination.

ASCQR Program Quality Measure Set (Page 677)

The rule's table 75 summarizes the previously finalized ASCQR Program measure set for the CY 2024 reporting period/ CY 2026 payment determination and the CY 2024 reporting period/ CY 2026 payment determination.

Proposed ASCQR Program Measure Set for the CY 2024 Reporting Period/CY 2026 Payment Determination

ASC #	NQF #	Measure Name
ASC-1	0263†	Patient Burn
ASC-2	0266†	Patient Fall
ASC-3	0267†	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4	0265†	All-Cause Hospital Transfer/Admission
ASC-9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients**
ASC-11	1536†	Cataracts Visual Function (Previously referred to as Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery)*
ASC-12	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
ASC-13	None	Normothermia Outcome
ASC-14	None	Unplanned Anterior Vitrectomy
ASC-17	3470	Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures
ASC-18	3366	Hospital Visits after Urology Ambulatory Surgical Center Procedures
ASC-19	3357	Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed atAmbulatory Surgical Centers
ASC-20	None	COVID-19 Vaccination Coverage Among Health Care Personnel**

† CBE endorsement was removed.
** In the CY 2023 OPPS/ASC final rule), CMS finalized to keep data collection and submission voluntary for this measure for the CY 2025 reporting period and subsequent years. In this proposed rule, CMS proposes to standardize the surveys offered to patients pre- and post-surgery beginning with the CY 2024 reporting period/CY 2026 payment determination.*
*** In this proposed rule, CMS proposes measure modifications to the Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients and COVID-19 Vaccination Coverage Among HCP measures that begin with the CY 2024 reporting period/CY 2026 payment determination.*

The rule's table 76 summarizes the previously finalized and newly proposed ASCQR Program measures for the CY 2025 reporting period/CY 2027 payment determination. (Page 678)

Proposed ASCQR Program Measure Set for the CY 2025 Reporting Period/ CY 2027 Payment Determination

ASC #	NQF #	Measure Name
ASC-1	0263†	Patient Burn
ASC-2	0266†	Patient Fall
ASC-3	0267†	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4	0265†	All-Cause Hospital Transfer/Admission
ASC-7	None	ASC Procedure Volume (Previously referred to as ASC Facility Volume onSelected ASC Surgical Procedures)**
ASC-9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for NormalColonoscopy in Average Risk Patients
ASC-11	1536†	Cataracts Visual Function (Previously referred to as Cataracts: Improvement inPatient's Visual Function within 90 Days Following Cataract Surgery)*
ASC-12	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
ASC-13	None	Normothermia Outcome
ASC-14	None	Unplanned Anterior Vitrectomy
ASC-15a	None	The Outpatient and Ambulatory Surgery Consumer Assessment of HealthcareProviders and Systems (OAS CAHPS) - About Facilities and Staff
ASC-15b	None	OAS CAHPS - Communication About Procedure
ASC-15c	None	OAS CAHPS - Preparation for Discharge and Recovery
ASC-15d	None	OAS CAHPS - Overall Rating of Facility
ASC-15e	None	OAS CAHPS - Recommendation of Facility
ASC-17	3470	Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures
ASC-18	3366	Hospital Visits after Urology Ambulatory Surgical Center Procedures
ASC-19	3357	Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers
ASC-20	None	COVID-19 Vaccination Coverage Among Health Care Personnel
ASC-21	3636	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)***

† CBE endorsement was removed.
* In the CY 2023 OPPS/ASC final rule CMS finalized to keep data collection and submission voluntary for this measure for the CY 2025 reporting period and subsequent years.
** CMS proposes to readopt the ASC Procedure Volume measure as a voluntary measure beginning with the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.
*** CMS proposes to adopt 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) as a voluntary measure beginning with the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2027 reporting period/CY 2030 payment determination.

Comment

The OQR and ASCQR sections contain much more information than the material presented above. Items not addressed include potential future additions; the form, manner and timing of data submissions; and, extraordinary exceptions.

Overall, the OQR and ASCQR total some 130 pages. Every year it appears that rule continues to grow in overall length. A good portion of the material is historical information. Last year's proposed rule display copy totaled 886 pages. This current proposal extends 963 pages.

There are a number of sections in the quality arena that describe items from previous rulemaking. Yet, the conclusions in these sections say, "We are not proposing any changes to these policies in this proposed rule." (see pages 600 ff , 679 ff and 690 ff for examples)

XVI. PROPOSED REQUIREMENTS FOR THE RURAL EMERGENCY HOSPITAL QUALITY REPORTING (REHQR) PROGRAM (Page 694)

CMS proposes to adopt four measures: (1) Abdomen Computed Tomography (CT) - Use of Contrast Material; (2) Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients; (3) Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy; and (4) Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery – for the REHQR Program measure set. (Page 697)

Comment

This section extends some 50 pages. To a large degree, CMS is repeating its concepts of quality reporting of other programs here.

XVII. CHANGES TO COMMUNITY MENTAL HEALTH CENTER (CMHC) CONDITIONS OF PARTICIPATION (COPS) (Page 744)

Section 4124 of the CAA, 2023 provides intensive outpatient services to be included as services provided by CMHCs under the Medicare Program.

Additionally, the CAA, 2023 established a new Medicare benefit category for Mental Health Counselor (MHC) services and Marriage and Family Therapist (MFT) services furnished by and directly billed by MHCs and MFTs, respectively.

To implement these provisions of the CAA, 2023, CMS is proposing to modify the requirements for the CMHC to include IOP services throughout the CoP. Additionally, current CoPs require that a CMHC must provide at least 40% of its services to individuals who are not eligible for Medicare Part B. If a CMHC fails to meet this requirement, their Medicare enrollment will be denied or revoked. Therefore, CMS is soliciting comments on how the provision of the IOP services may impact the populations CMHCs serve as well as the potential impact on meeting the 40% requirement. CMS is also proposing to modify the CMHC CoPs for personnel qualifications for certain disciplines to revise the current definition of mental health counselors and add a definition of marriage and family therapists.

XVIII. PROPOSED UPDATES TO REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES (Page 752)

CMS' hospital price transparency (HPT) regulations "lay the foundation for a patient-driven health care system" by making hospital standard charges' data available to the public.

CMS proposes to: (1) define several terms; (2) revise the standard charge information and data elements that hospitals must include in their machine readable formats (MRFs), as well as require hospitals to use a template developed by CMS (hereafter referred to as a 'CMS template') for purposes of complying with regulation § 180.50, in order to standardize the displayed MRF data; (3) improve the accessibility of the hospital MRF by requiring 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; and (4) improve the agency's enforcement process by updating 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.

Comment

This is another long and detailed section. It's more than 50 pages with modifications to the reporting methods hospitals need to meet compliance. Failure to comply could be extremely costly inasmuch as CMS has set penalties as high as $2 million for large institutions.

XIX. PROPOSED CHANGES TO THE INPATIENT PROSPECTIVE PAYMENT SYSTEM MEDICARE CODE EDITOR (Page 808)

Beginning with the FY 2025 rulemaking, CMS would no longer address the addition or deletion of MCE edits or the addition or deletion of ICD-10 diagnosis and procedure codes for the applicable MCE edit code lists in the annual IPPS rulemakings.

XX. PROPOSED TECHNICAL EDITS FOR REH CONDITIONS OF PARTICIPATION AND CRITICAL ACCESS HOSPITAL (CAH) COP UPDATES (Page 812)

CMS proposes to correct statutory citations from "1881(d)(2)(D)" to "1886(d)(2)(D)" and from "1881(d)(1)(B)" to "1886(d)(1)(B)" at § 485.506(b) and (c).

FINAL THOUGHTS

As previously noted, this analysis does not include all material expressed in the rulemaking. Nonetheless there is an additional item we want to briefly address here.

CMS is suggesting the establishment of separate payments for the establishment under the IPPS and OPPS to cover a "Buffer Stock of Essential Medicines". Issues still to be resolved are the list of such medicines and costs.

The roman numeral items in bold and all caps follow CMS' table of contents.

The reader should not overlook CMS' Economic Analyses (Page 872). CMS devotes much attention to costs of the changes being proposed.