Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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

The Centers for Medicare & Medicaid Services (CMS) have issued its final 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 1,672-page rule is scheduled for publication in the ***Federal Register*** on November 22. A copy is currently available at: https://public-inspection.federalregister.gov/2023-24293.pdf

The rule includes updates and refines requirements for the Hospital Outpatient Quality Reporting (OQR) Program, the ASC Quality Reporting (ASCQR) Program, and the Rural Emergency Hospital Quality Reporting (REHQR) Program. The rule includes updated requirements for hospitals to make public their standard charge information and enforcement of hospital price transparency. CMS is finalizing changes to the community mental health center (CMHC) Conditions of Participation (CoPs) to provide requirements for furnishing intensive outpatient services (IOP), and CMS is finalizing proposed personnel qualifications for mental health counselors (MHCs) and marriage and family therapists (MFTs). Additionally, CMS is finalizing the removal of the discussion of inpatient prospective payment system (IPPS) Medicare Code Editor (MCE) from the annual IPPS rulemakings, beginning with the fiscal year (FY) 2025 rulemaking. Finally, CMS is finalizing a technical correction to the Rural Emergency Hospital (REH) CoPs under the standard for the designation and certification of REHs.

The Addenda relating to the OPPS are available at:
https://www.cms.gov/medicare/payment/prospectivepayment-systems/hospital-outpatient/regulations-notices.

The Addenda relating to the ASC payment system are available at:
https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices.

Comments

CMS notes the policies in this rule will affect approximately 3,500 hospitals and 6,000 ASCs. The hospital price transparency policies will impact over 7,000 institutions licensed as hospitals.

CMS says it received approximately 3,777 timely pieces of correspondence on the CY 2024 OPPS/ASC proposed rule.
CMS has provided, in some cases, different numbers for payment increase from CYs 2023 to 2024.

While CMS has provided a *condensed* table of contents, we are adding page numbers (in red) to help readers locate specific items we are addressing.

Unlike other recent CY 2024 PPS updates that provided clear "Final Decision" sections, this rule contains an array of such actions. Most conclusions are addressed "After Consideration(s)." Unfortunately a lack of consistency is not helpful to the reader.

There are many items in the rule not addressed in this summary and analysis.

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

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I. SUMMARY of SELECT PROVISIONS (Page 15)

The following is a summary of select items from the regulation's preamble text.

OPPS Update: (Page 17)

For 2024, CMS is increasing the payment rates by a fee schedule increase factor of 3.1 percent. This increase factor is based on the final inpatient hospital market basket percentage increase of 3.3 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a final productivity adjustment of 0.2 percentage point.

Based on this update, CMS estimates that total payments to OPPS providers (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case mix) will be approximately $88.9 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 quality reporting requirements by applying a reporting factor of 0.9806 to the OPPS payments and copayments for all applicable services.

As required by OMB, CMS has prepared accounting statements to illustrate the impacts of the OPPS and ASC changes. The first accounting statement, Table 171, illustrates the classification of expenditures for CY 2024 associated with the final CY 2024 OPD fee schedule increase.

The second accounting statement, Table 172, illustrates the classification of expenditures associated with the 3.1 percent CY 2024 update to the ASC payment system, based on the provisions of this final rule and the baseline spending estimates for ASCs. Both tables classify most estimated impacts as transfers.

Table 173 displays the annual estimated impact of hospital price transparency. (Page 1,603)

Table 171: 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	$2,110 million
From Whom to Whom	Federal to outpatient hospitals and other providers who receive payment under the hospital OPPS

Table 172: Accounting Statement: Classification Of Estimated Transfers From CY 2023 To CY 2024 As A Result Of The Final CY 2024 Updated To The ASC Payment System

Category	Transfers
Annualized Monetized Transfers	$170 million
From Whom to Whom	Federal Government to Medicare Providers and Suppliers

Table 173: Estimated Costs In CY 2024 For Hospital Price Transparency

Category	Costs
Burden	$75.147million
Regulatory Familiarization	$3.715 million*

** Regulatory familiarization costs occur upfront only.*

Partial Hospitalization Update: (Page 18)

CMS is finalizing changes to its methodology used to calculate the Community Mental Health Center (CMHC) and hospital-based PHP (HB PHP) geometric mean per diem costs. CMS is also finalizing changes to expand PHP payment from two APCs to four APCs.

Medicare Payment for Intensive Outpatient Programs: (Page 18)

Beginning in CY 2024, CMS is finalizing payment for intensive outpatient program (IOP) services. CMS is finalizing 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). CMS is also finalizing payment for intensive outpatient services provided by opioid treatment programs (OTPs) under the existing OTP benefit.

Changes to the Inpatient Only (IPO) List: (Page 18)

For 2024, CMS is not removing any services from the IPO list.

340B–Acquired Drugs: (Page 18)

For 2024, drugs and biologicals acquired under the 340B program will be paid at the same payment rate as those drugs and biologicals not acquired under the 340B program. That is ASP +6.0 percent.

Biosimilar Packaging Exception: (Page 19)

For CY 2024, CMS is finalizing its proposal to except biosimilars from the OPPS threshold packaging policy when their reference products are separately paid. However, CMS is not finalizing that all the biosimilars related to the reference product would be similarly packaged if a reference product's per-day cost falls below the threshold packaging policy.

Device Pass-Through Payment Applications: (Page 19)

For CY 2024, CMS received 6 applications for device pass-through payments. CMS approved four.

Cancer Hospital Payment Adjustment: (Page 19)

CMS is continuing to provide additional payments to 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 will 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 is setting a target PCR of 0.88. That is, the payment adjustments will be the additional payments needed to result in a PCR equal to 0.88 for each cancer hospital.

ASC Payment Update: (Page 20)

CMS is increasing payment rates under the ASC payment system by 3.1 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. Based on this final 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 $7.1 billion, an increase of approximately $207 million compared to estimated CY 2023 Medicare payments.

Comment

In the accounting table 172 (above) CMS says the increase for CY 2024 will be $170 million more than 2023. Yet, here CMS says the increase will be $207 million more.

Changes to the List of ASC Covered Surgical Procedures: (Page 20)

CMS is adding 37 surgical procedures, including total shoulder arthroplasty (TSA) (Healthcare Common Procedure Coding System (HCPCS) code 23472), to the ASC covered procedures list (CPL) based upon existing criteria at § 416.166.

Hospital Outpatient Quality Reporting (OQR) Program: (Page 20)

CMS is finalizing its proposals to: (1) modify the COVID–19 Vaccination Coverage Among Healthcare 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 voluntary CY 2024 reporting period; (3) 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; and (4) 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.

CMS is finalizing with modification the proposal to adopt the Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO-PM) with voluntary reporting beginning with the CY 2025 reporting period through the CY 2027 reporting period followed by mandatory reporting beginning one year later than proposed with the CY 2028 reporting period/CY 2031 payment determination.

CMS is finalizing with modification the proposal to adopt the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient)

measure with voluntary reporting beginning with the CY 2025 reporting period and mandatory reporting beginning 1 year later than proposed with the CY 2027 reporting period/CY 2029 payment determination.

CMS is not finalizing its proposal to remove the Left without Being Seen measure. CMS is also not finalizing its proposal to re-adopt with modification the Hospital Outpatient Volume Data on Selected Outpatient Procedures measure.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program: (Page 22)

CMS is finalizing its proposals 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; and (4) 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.

CMS is finalizing with modification the proposal to adopt the Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM) with voluntary reporting beginning with the CY 2025 reporting period through the CY 2027 reporting period followed by mandatory reporting beginning one year later than proposed with the CY 2028 reporting period/CY 2031 payment determination.

CMS is not finalizing its proposal to re-adopt with modification the ASC Facility Volume Data on Selected ASC Surgical Procedures measure.

Rural Emergency Hospital Quality Reporting (REHQR) Program*:* (Page 22)

CMS is finalizing its proposals to: (1) codify the statutory authority for the REHQR Program; (2) adopt and codify policies related to measure retention and measure modification; (3) adopt one chart-abstracted measure, Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients, beginning with the CY 2024 reporting period; (4) adopt three claims-based measures, Abdomen Computed Tomography (CT) - Use of Contrast Material; Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy; and, Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery, beginning with the CY 2024 reporting period; (5) establish related reporting requirements beginning with the CY 2024 reporting period; (6) adopt and codify policies related to public reporting of data; (7) codify foundational requirements related to REHQR Program participation; (8) adopt and codify policies related to the form, manner, and timing of data submission under the REHQR Program; (9) adopt and codify a review and corrections period for submitted data; and (10) adopt and codify an Extraordinary Circumstances Exception (ECE) process for data submission requirements.

CMS is finalizing with modification the proposal to adopt and codify a policy related to immediate

measure removal such that it is referred to more appropriately as immediate measure suspension. In such a case, a quality measure considered by CMS to have potential patient safety concerns will be immediately suspended from the program and then addressed in the next appropriate rulemaking cycle.

Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes (Page 23)

CMS is finalizing technical refinements to the existing coding for remote mental health services to allow for multiple units to be billed daily. CMS is also finalizing to create a new, untimed code to describe group psychotherapy. CMS is delaying the in person visit requirements until January 1, 2025.

OPPS Payment for Dental Services: (Page 23)

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 Physician Fee Schedule (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 24)

To comply with section 51008 of the ***Bipartisan Budget Act*** of 2018 and to ensure consistency with final revisions to §§ 410.47 and 410.49 in the CY 2024 PFS final rule, CMS is revising § 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 is also allowing 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.

Payment for Intensive Cardiac Rehabilitation Services (ICR) Provided by an Off-Campus, Non-Excepted Provider Based Department (PBD) of a Hospital: (Page 24)

To address an unintended reimbursement disparity created by application of the off-campus, nonexcepted payment rate to intensive cardiac rehabilitation services (ICR), CMS is paying for ICR services furnished by an off-campus, non-excepted PBD of a hospital at 100 percent of the OPPS rate, which is the amount paid for these services under the PFS.

Final Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges: (Page 25)

CMS is finalizing its proposals to revise several of the Hospital Price Transparency (HPT) requirements in order to improve monitoring and enforcement capabilities by improving access to, and the usability of, hospital standard charge information; reducing the compliance burden on hospitals by providing CMS templates and technical guidance for display of hospital standard charge information; aligning, where feasible, certain HPT requirements and processes with requirements and processes CMS has

implemented in the Transparency in Coverage (TIC) initiative; and making other modifications to monitoring and enforcement capabilities that will, among other things, increase its transparency to the public.

Specifically, CMS is finalizing: (1) definitions of several terms; (2) a requirement that hospitals make a good faith effort to ensure standard charge information is true, accurate, and complete, and to include a statement affirming this in the machine-readable file (MRF); (3) new data elements that hospitals must include in their MRFs, as well a requirement that hospitals encode standard charge information in a CMS template layout; (4) phased implementation timeline applicable to the new requirements; (5) a requirement that hospitals include a .txt file in the root folder that includes a direct link to the MRF; and (6) improvements to 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.

CMS is finalizing that the effective date of the changes to the hospital price transparency regulations at 45 CFR part 180 will be January 1, 2024. However, the regulation text will specify later dates by which hospitals must be in compliance with some of these new requirements, and CMS will begin enforcing those requirements on those specified dates. CMS says it believes this phased implementation approach is necessary to provide hospitals time to collect and encode the required standard charge information completely and accurately.

Community Mental Health Center (CMHC) Conditions of Participation (CoPs): (Page 26)

The ***Consolidated Appropriations Act*** (CAA) established coverage of intensive outpatient (IOP) services in CMHCs beginning January 1, 2024.

Section 4121 of the CAA also established a new Medicare benefit category for services furnished and directly billed by Mental Health Counselors (MHCs) and Marriage and Family Therapists (MFTs). CMS is finalizing, as proposed, to modify the requirements for CMHCs to include IOP services throughout the CoPs. CMS also is finalizing its proposal to modify the CMHC CoPs for personnel qualifications to add a definition of marriage and family therapists and revise the current definition of mental health counselors.

Changes to the Inpatient Prospective Payment System Medicare Code Editor: (Page 26)

CMS is finalizing its proposal to remove discussion of the IPPS Medicare Code Editor (MCE) from the annual IPPS rulemakings, beginning with the FY 2025 rulemaking, and to generally address future changes or updates to the MCE through instruction to the MACs.

II. UPDATES AFFECTING OPPS PAYMENTS (Page 37)

A. Recalibration of APC Relative Payment Weights (Page 37)

Calculation of Single Procedure APC Criteria-Based Costs

- *Blood and Blood Products* (Page 47)

CMS will continue to establish payment rates for blood and blood products using its blood-specific CCR methodology. Addendum B contains the final CY 2024 payment rates for blood and blood products at: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospitaloutpatient/regulations-notices.

- *Brachytherapy Sources* (Page 49)

  CMS is finalizing, without modification, to use its equitable adjustment authority under section 1833(t)(2)(E) of the Act to maintain the CY 2023 payment rate of $4.69 per mm2 for HCPCS code C2645, which is assigned to APC 2648 (Brachytx planar, p-103), for CY 2024.

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

Comprehensive APCs (C-APCs) for CY 2024 (Page 54)

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 available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospitaloutpatient/regulations-notices. (Page 55)

The specific C–APC complexity adjustment code combinations requested by commenters for CY 2024 are listed in the rule's Table 1. (Page 63)

CMS is finalizing, as proposed, C–APCs 5342 (Level 2 Abdominal/Peritoneal/Biliary and Related Procedures APC) and 5496 (Level 6 Intraocular APC).

The rule's Table 2 lists the C-APCs for CY 2024. (Page 74)

Calculation of Composite APC Criteria-Based Costs (Page 77)

- *Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)* (Page 81)

  The rule's Table 3 (Page 83) lists the HCPCS codes that will be subject to the multiple imaging composite APC policy and their respective families and approximate composite APC geometric mean costs for CY 2024.

B. Conversion Factor (CF) (Page 105)

For 2024, CMS will use an OPPS conversion factor of **$87.382** as calculated below. (Page 115)

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 0.9912. This adjustment reduces the amount of OPPS outpatient hospital spending and is multiplied with $86.589. ➢ $86.589* 0.9912 = **$85.827**
Step 3:	Adjust the conversion factor by the proposed 5 percent annual cap for individual hospital wage index reductions adjustment of approximately 0.9977. This adjustment reduces the amount of outpatient hospital spending and is multiplied with $85.827 ➢ $85.827*0.9997 = **$85.802**
Step 4:	Adjust the conversion factor by the 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 $85.802 ➢ $85.802*1.0005 = **$85.845**
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. ➢ $85.845*1.0000 = **$85.845**
Step 6a:	Adjust the conversion factor by the OPD fee schedule increase factor of 0.031 for CY 2024. The 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+0.031= 1.0310
Step 6b:	Multiply $85.845 by 1.0310. ➢ $85.845*1.0310 = **$88.506**
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 (0.0027) 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– (0.0027+0.01) = 0.9873
Step 7b:	Multiply $88.506 by 0.9873 to get the CY 2024 OPPS conversion factor. 1. $88.605/0.9874 = **$87.382**
Finish:	**CY 2024 OPPS Conversion Factor = $87.382**

C. Wage Index Changes (Page 117)

The OPPS labor-related share will remain at 60 percent of the national OPPS payment.

CMS is finalizing its proposal without modification to use the FY 2024 IPPS post-reclassified wage index for urban and rural areas as the wage index for the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment rate for CY 2024. (Page 124)

Addendum L at: https://www.cms.gov/medicare/payment/prospective-paymentsystems/hospital-outpatient/regulations-notices is a link to the FY 2024 IPPS wage index tables.

D. Statewide Average Default CCRs (Page 95)

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

E. 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 128)

For CY 2024, CMS will continue its current policy of a 7.1 percent 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. Payment Adjustment for Certain Cancer Hospitals for CY 2024 (Page 128)

The rule's Table 6 has the estimated percentage increase in OPPS payments to each of the 11 eligible cancer hospital for CY 2024. (Page 135)

G. Hospital Outpatient Outlier Payments (Page 135)

Using CY 2022 claims data and CY 2023 payment rates, CMS estimates that the aggregate outlier payments for CY 2023 will be approximately 0.83 percent of the total CY 2023 OPPS payments.

CMS says that to ensure that the estimated CY 2024 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, CMS will set 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 **$7,750.** (Page 141)

CMS says that the proposed outlier amount of $8,350 was in error. It should have been $6,875.

The current payment amount is $8,625.

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

III. OPPS AMBULATORY PAYMENT CLASSIFICATION (APC) GROUP POLICIES (Page 157)

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 8. (Page 160)

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 9. (Page 164)

3. *October 2023 HCPCS Codes* (Page 168)

   For the October 2023 update, 64 new codes were established and made effective October 1, 2023. The codes and long descriptors are listed in the rule's Table 10. (Page 169)

4. *January 2023 HCPCS Codes* (Page 173)

   For CY 2024, CMS will 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. OPPS Changes – Variations within APCs (Page 177)

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 12 lists 22 APCs that CMS will exempt from the 2 times rule for CY 2024. (Page 184)

C. New Technology APCs (Page 184)
The procedures approved to be assigned to New Technology APCs are listed below.

a. Administration of Subretinal Therapies Requiring Vitrectomy (APC 1563) (Page 189)
b. Bronchoscopy with Transbronchial Ablation of Lesion(s) by Microwave Energy (APC 1562) (Page 194)
c. Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies (APCs 1520, 1521, and 1522) (Page 196)
d. V-Wave Medical Interatrial Shunt Procedure (APC 1590) (Page 206)
e. Corvia Medical Interatrial Shunt Procedure (APC 1592) (Page 209)
f. Supervised Visits for Esketamine Self-Administration (APCs 1513 and 1520) (Page 212)
g. DARI Motion Procedure (APC 1505) (Page 217)
h. Liver Histotripsy Service (APC 1576) (Page 218)
i. Liver Multiscan Service (APC 1505) (Page 222)
j. Minimally Invasive Glaucoma Surgery (MIGS) (APC 5493) (Page 225)
k. Scalp Cooling (APC 1514) (Page 230)
l. Optellem Lung Cancer Prediction (LCP) (APC 1508) (Page 233)
m. Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP) (APC 1511) (Page 235)
n. CardiAMP (APC 1590) (Page 238)
o. Surfacer® Inside-Out® Access Catheter System (APC 1534) (Page 240)
p. Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (APC 1580) (Page 242)
q. Cleerly Labs (APC 1511) (Page 245)

D. Universal Low Volume APC Policy for Clinical and Brachytherapy APCs (Page 249)

The rule's Table 46 (Page 251) lists the APCs.

E. APC-Specific Policies:

CMS has made changes to the following APCs:

1. *Ablation of Bone Tumors CPT Code 20982 (APC 5115)* (Page 253)
2. *Administration of Lacrimal Ophthalmic Insert Into Lacrimal Canaliculus (APC 5503)* (Page 254)
3. *Aquabeam Waterjet Ablation Service CPT Code 0421T (APC 5376)* (Page 261)
4. *Aquadex® Ultrafiltration (APC 5241)* (Page 262)
5. *Aqueous Shunt Procedure (APC 5492)* (Page 264)
6. *Arthrodesis, Sacroiliac Joint, Percutaneous, with Image Guidance, Including Placement of Intra-Articular Implant(s) (e.g., Bone Allograft[s], Synthetic Device[s]), Without Placement of Transfixation Device (APC 5116)* (Page 265)
7. *Artificial Iris Insertion Procedures (APC 5496)* (Page 266)
8. *Autologous Adipose-Derived Regenerative Cell (ADRC) Therapy for Partial Thickness Rotator Cuff Tear (APC 5055)* (Page 269)
9. *Barostim CPT Code 0266T (APC 1580)* (Page 270)
10. *Barricaid® Spine/Lumbar Disk Surgery (APC 5115)* (Page 272)

A. 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 396)

   Currently, there are 15 device categories eligible for pass-through payment. These devices are listed in the rule's Table 84. (Page 397)

2. *New Device Pass-Through Applications* (Page 398)

   CMS says it received "six" complete applications by the March 1, 2023 quarterly deadline. (Page 402)

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

      (1) CavaClear Inferior Vena Cava (IVC) Filter Removal Laser Sheath (Page 403)
      Approved (Page 418)

      (2) CERAMENT® G (Page 418)
      Approved (Page 435)

   2. Four are based on the Traditional Device Pass-through Applications (Page 436)

      (1) Ambu® aScopeTM 5 Broncho HD (Page 436)
      Approved (Page 471)

(2) Praxis Medical CytoCore (Page 471)
Not approved (Page 477)

(3) EchoTip® (Page 477)
Not Approved (Page 493)

(4) *FLEX Vessel Prep™ System* (Page 493)
Approved (Page 510)

B. Device-Intensive Procedures (Page 510)

The full listing of the CY 2024 device-intensive procedures can be found in Addendum P. (Page 521)

V. OPPS PAYMENT FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS (Page 528)

A. 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 531)

There are 43 drugs and biologicals for which pass-through payment status expires by December 31, 2023, as listed in the rule's Table 89. (Page 532)

2. Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Expiring in CY 2024. (Page 536)

CMS will 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 90. (Page 539)

3. Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Continuing through CY 2024. (Page 541)

CMS will 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 . (Page 543)

B. OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Payment Status (Page 553)

1. Packaging Threshold. (Page 554)

The packaging threshold for CY 2024 was proposed at $140**.** CMS will keep the current amount of **$135** for CY 2024.

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 554)

Refer to Addendum B for information on the packaging status of drugs, biologicals, and therapeutic radiopharmaceuticals. (Page 558)

3. Packaging Determination for HCPCS Codes that Describe the Same Drug or Biological but Different Dosages. (Page 560)

The packaging status of each drug and biological HCPCS code to which this methodology will apply in CY 2024 is displayed in the rule's Table 93. (Page 562)

Biosimilar Biological Products (Page 569)

The ***Inflation Reduction Act of 2022*** (IRA) requires a temporary increase in the add-on payment for qualifying biosimilar biological products from 6 percent to 8 percent 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.

Except Biosimilars from the OPPS Packaging Threshold When Their Reference Products Are Separately Paid

CMS is finalizing the exception of biosimilars from the OPPS threshold packaging policy when their reference products are separately paid, meaning for CY 2024, CMS would pay separately for these biosimilars even if their per-day cost is below the threshold packaging policy. *(*Page 578)

Payment for Blood Clotting Factors (Page 583)

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.

For CY 2024, CMS "will continue to pay for blood clotting factors using the same methodology as other separately payable drugs and biologicals under the OPPS and will continue to pay an updated furnishing fee. CMS will announce the actual figure of the percent change in the applicable CPI and the updated furnishing fee calculation based on that figure through the applicable program instructions and posting on the CMS website."

OPPS Payment Methodology for 340B Purchased Drugs and Biologicals

CMS is finalizing its proposal without modification to require that all 340B covered entity hospitals paid under the OPPS report the "TB" modifier effective January 1, 2025, even if the hospital previously reported the "JG" modifier, for 340B-acquired drugs and biologicals.

CMS says it believes the transition to a single 340B modifier "TB" will allow for greater simplicity, especially because both modifiers are used for the same purpose to continue to identify and exclude

340B-acquired drugs and biologicals from the definition of units for the purpose of Part B inflation rebate liability. The "JG" modifier will remain effective through December 31, 2024. Hospitals that currently report the "JG" modifier may choose to continue to use it in CY 2024 or choose to transition to use of the "TB" modifier sooner, provided all hospitals are using the "TB" modifier by January 1, 2025. (Page 597)

High Cost/Low-Cost Threshold for Packaged Skin Substitutes

Skin substitutes assigned to the high-cost group are described by HCPCS codes 15271, 15273, 15275, or 15277. Skin substitutes assigned to the low-cost group are described by HCPCS codes C5271 through C5278.

The CY 2024 mean unit cost (MUC) threshold is $47 per cm2 (rounded to the nearest $1) and the CY 2024 per day cost (PDC) threshold is $807 (rounded to the nearest $1).

The rule's Table 95 includes the CY 2024 cost category assignment for each skin substitute product. (Page 613)

VI. ESTIMATE OF OPPS TRANSITIONAL PASS-THROUGH SPENDING FOR DRUGS, BIOLOGICALS, RADIOPHARMACEUTICALS, AND DEVICES (Page 631)

CMS estimates the amount of pass-through spending for device categories, drugs, and biologicals that first become eligible for pass-through payment during CY 2024 would be approximately $236 million (approximately $127.5 million for device categories and approximately $108.5 million for drugs and biologicals), which represents only 0.27 percent of total projected OPPS payments for CY 2024 (approximately $88.9 billion). Therefore, CMS estimates that pass-through spending in CY 2024 will not exceed the 2.0 percent of total projected OPPS CY 2024 program spending limit provided for in section 1833(t)(6)(E) of the Act.

VII. OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS AND CRITICAL CARE SERVICES (Page 631)

CMS will continue to utilize the 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 percent of the OPPS payment (that is, 60 percent less than the OPPS rate). (Page 632)

VIII. PAYMENT FOR PARTIAL HOSPITALIZATION SERVICES AND INTENSIVE OUTPATIENT SERVICES (Page 639)

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 644)

Intensive Outpatient Program Services (Page 647)

CMS finalizing its proposed definition at § 410.2 for intensive outpatient services: Intensive outpatient services means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.44. (Page 654)

The 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).

CMS is finalizing its proposals without modification to add the statutory basis for IOP at CMHCs at §488.2 and to revise the provision at 42 CFR 489.2(c)(2) so that CMHCs may enter into provider agreements to furnish IOP services. (Page 663)

CMS is finalizing without modification its proposed regulations at § 410.155(b)(2)(iii) to state that intensive outpatient services not directly provided by a physician are not subject to the outpatient mental health treatment limitation. (Page 667)

CMS is finalizing, without modification, its proposal to codify the content of the certification and plan of treatment requirements for intensive outpatient services at § 424.24(d). (Page 670)

Coding and Billing for PHP and IOP Services under the OPPS (Page 670)

Beginning January 1, 2024, CMS will require the use of condition code 41 on all PHP claims from hospitals and CMHCs and require the use of condition code 92 on all IOP claims from hospitals and CMHCs. (Page 672)

The final list of Partial Hospitalization and Intensive Outpatient Primary Services is found in table 99. (Page 695)

Payment Rate Methodology for PHP and IOP (Page 695)

CMS is finalizing its proposal to establish separate APC per diem payment rates for PHP days with 3 services and 4 or more services and to establish separate APC per diem payment rates for CMHCs and hospital-based PHPs. CMS is also finalizing its proposal to set APC per diem payment rates for IOP days based on the APC per diem payment rates for PHP in CY 2024.

Lastly, CMS is finalizing its proposal to make payment at the 3-service rate for PHP or IOP days that have fewer than 3 services. (Page 706)

The final CY 2024 PHP and IOP APC per diem rates are included in Addendum A and in Table 101 (below). (Page 710)

Table 101 CY 2024 PHP and IOP APC Geometric Mean Per Diem Costs

CY 2024 APC	Group Title	Final PHP and IOP APC Geometric Mean Per Diem Costs
5851	Intensive Outpatient (3 services per day) for CMHCs	$90.02
5852	Intensive Outpatient (4 or more services per day) for CMHCs	$161.80
5853	Partial Hospitalization (3 services per day) for CMHCs	$90.02
5854	Partial Hospitalization (4 or more services per day) for CMHCs	$161.80
5861	Intensive Outpatient (3 services per day) for hospital-based IOPs	$266.35
5862	Intensive Outpatient (4 or more services per day) for hospital-based IOPs	$367.79
5863	Partial Hospitalization (3 services per day) for hospital-based PHPs	$266.35
5864	Partial Hospitalization (4 or more services per day) for hospital-based PHPs	$367.79

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (Page 747)

CMS says it is finalizing a payment methodology to price HCPCS code GOTP1 based on the estimated payment rate of 3 services per day based on APC 5861 (Intensive Outpatient (1-3 services) for Hospital-based IOPs), which is "$259.40," multiplied by 3 to reflect 3 days a week (for a weekly payment methodology), which results in a final payment rate of $778.20. (Page 780)

Comment

Note that the table above says APC 5861 has a daily rate of $266.35. In the paragraph above, CMS says the payment for APC 5861 is $259.40. Which is it?

This is a very long section—nearly 250 pages. It is somewhat redundant and confusing. Too much history.

IX. SERVICES THAT WILL BE PAID ONLY AS INPATIENT SERVICES (Page 791)

CMS did not propose to remove any services from the IPO list for CY 2024.

However, CMS proposed 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 would be effective on January 1, 2024.

The CPT codes, long descriptors, and the CY 2024 payment indicators are displayed in the rule's Table 103. (Page 800)

X. NONRECURRING POLICY CHANGES (Page 802)

CMS addresses the following non-recurring policy changes.

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 802)
B. Payment for Intensive Cardiac Rehabilitation Services (ICR) Provided by an Off-Campus, Non-Excepted Provider Based Department (PBD) of a Hospital (Page 814)
C. OPPS Payment for Specimen Collection for COVID–19 Tests (Page 823)
D. Remote Services (Page 824)
E. OPPS Payment for Dental Services (Page 835)
F Use of Claims and Cost Report Data for CY 2024 OPPS and ASC Payment System Rate Setting Due to the PHE (Page 869)
G. Comment Solicitation on Payment for high-cost drugs, provided by Indian Health Service and Tribal Facilities (Page 873)
H. Technical changes to hospital billing for marriage and family therapist services and mental health counselor services (Page 877)

XI. CY 2024 OPPS PAYMENT STATUS AND COMMENT INDICATORS (Page 881)

The complete list of CY 2024 payment status indicators and their definitions is displayed in Addendum D1, which is available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospitaloutpatient/regulations-notices.

The CY 2024 payment status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B.

The complete list of proposed CY 2024 payment status indicators and their definitions is displayed in Addendum D1

CY 2024 Comment Indicator Definitions (Page 882)

The definitions of the OPPS comment indicators for CY 2024 are listed in Addendum D2

XII MEDPAC RECOMMENDATIONS (Page 883)

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

XIII. UPDATES TO THE AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM (Page 885)

A. Calculation of the ASC Payment Rates and the ASC Conversion Factor (Page 1002)

For CY 2024, CMS is adjusting the CY 2023 ASC conversion factor ($51.854) by a wage index budget neutrality factor of 1.0010 in addition to the productivity-adjusted hospital market basket update of 3.1 percent, which results in a final CY 2024 ASC conversion factor of **$53.514** for ASCs meeting the quality reporting requirements.

For ASCs not meeting the quality reporting requirements, CMS is adjusting the CY 2023 ASC conversion factor ($51.854) by the wage index budget neutrality factor of 1.0010 in addition to the reduced

productivity-adjusted hospital market 1.1 percent which results in a final CY 2024 ASC conversion factor of **$52.476.**

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. ASC Treatment of New and Revised Codes (Page 886)

1. April 2023 HCPCS Codes (Page 888)

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

The rule's Table 112 lists the new Level II HCPCS codes implemented April 1, 2023. (Page 890)

2. July 2023 HCPCS Codes Rule Comment Solicitation (Page 891)

Table 113 (New HCPCS Codes for Covered Surgical Procedures and Covered Ancillary Services Effective July 1, 2023) lists the new HCPCS codes that were effective July 1, 2023.

3. October 2023 HCPCS Codes Final Rule Comment Solicitation (Page 893)

Refer Table 114 (Page 894)

4. January 2024 HCPCS Codes (Page 894)

Similar to the codes effective October 1, 2023, these new Level II HCPCS codes that will be effective January 1, 2024, will be subject to comment in the CY 2025 OPPS/ASC proposed rule, which would be finalized in the CY 2025 OPPS/ASC final rule.

C. Payment Policies Under the ASC Payment System (Page 900)

CMS is finalizing its proposed policies without modification to calculate the CY 2024 payment rates for ASC covered surgical procedures according to the agency's established rate calculation methodologies under § 416.171 and the device-intensive payment policy. The payment rate is the lesser of the final CY 2024 MPFS non-facility PE RVU-based amount or the final CY 2024 ASC payment amount calculated according to the ASC standard rate-setting methodology. The final payment indicators and rates set forth in this final rule are based on a comparison using the PFS PE RVUs and the conversion factor effective January 1, 2024. (Page 903)

CY 2024 ASC Special Payment Policy for OPPS Complexity-Adjusted C-APCs (Page 912)

CMS is finalizing the ASC special payment policy for OPPS complexity-adjusted C–APCs, as proposed. The final C codes for CY 2024 can be found in ASC Addendum AA.

Low Volume APCs and Limit on ASC Payment Rates for Procedures Assigned to Low Volume APCs (Page 912)

CMS is finalizing its proposal to designate the 4 clinical APCs and 5 brachytherapy APCs shown in Table 116 as Low Volume APCs under the ASC payment system, because they continue to meet CMS' criteria of having fewer than 100 single claims in the relevant claims year (2022). The APC cost metric for these APCS is based on the greatest of the median cost, arithmetic mean cost, or geometric mean cost using up to 4 years of claims data. (Page 913)

Device-Intensive ASC Covered Surgical Procedures (Page 928)

CMS did not propose any changes related to designating surgical procedures as device intensive under the ASC payment system for CY 2024. (Page 931)

CMS is finalizing its proposed device offset amounts for CPT codes 0627T, 0671T, 66989, 66991, 58356, 31242, 31243, 31295 and HCPCS codes C9734, C9757 and C9781. For final CY 2024 device offset percentages based see Addendum FF. (Page 934)

Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices (Page 937)

"We did not receive any comments on our policies related to no/cost full credit or partial credit devices, and we are continuing our existing policies for CY 2024." (Page 940)

D. Additions to ASC Covered Surgical Procedures and Covered Ancillary Services Lists (Page 941)

CMS says it believes that 11 procedures (HCPCS code C9734 and CPT codes 21194, 21195, 23470, 23472, 27702, 27006, 29868, 33289, 37192, 60260) out of the 235 procedure recommendations received can be safely performed for the typical beneficiary in the ASC setting and meet the general standards and exclusion criteria for the ASC CPL as set forth in 42 CFR 416.166(b) and (c), respectively. These 11 codes correspond to procedures that are frequently performed in outpatient settings and increasingly show lower risks of serious complications and inpatient admissions.

These procedures, are listed in Table 123. (Page 953)

E. ASC Payment Policy for Non-Opioid Post-Surgery Pain Management Drugs, Biologicals, and Devices *(Page 972)*

CMS is finalizing without modification, that the drugs described by HCPCS code C9290 (Injection, bupivacaine liposome, 1 mg); J1096 (Dexamethasone, lacrimal ophthalmic insert, 0. mg); HCPCS code J1097 (Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml); HCPCS code C9089 (Bupivacaine, collagen-matrix implant, 1 mg), continue to function as nonopioid pain management drugs and biologicals that function as surgical supplies and meet the criteria at § 416.174. Similarly, CMS is finalizing its proposal that HCPCS code C9144 (Injection, bupivacaine (posimir), 1 mg), no longer meets all of the criteria at § 416.174 and will not receive separate payment in the ASC setting under that policy.

The rule's table 125 lists the drugs that CMS considers 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 987)

F. New Technology Intraocular Lenses (NTIOLs) (Page 1,000)

CMS did not receive any requests 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 1,019)

Removal of the Left Without Being Seen Measure Beginning with the CY 2024 Hospital OQR Reporting Period

CMS is not, as proposed, finalizing its proposal to remove the LWBS measure beginning with the CY 2024 reporting period/CY 2026 payment determination. (Page 1,026)

Modifications to Previously Adopted Measures (Page 1,026)

CMS is modifying 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.

Adoption of New Measures for the Hospital OQR Program Measure Set (Page 1,060)

CMS will:

(1) not re-adopt the original Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures, 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 2028 reporting period/CY 2031 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 2027 reporting period/CY 2029 payment determination.

Previously Finalized and Proposed Hospital OQR Program Measure Sets (Page 1,121)

Table 128 (below) summarizes the previously finalized and newly finalized Hospital OQR Program measures beginning with the CY 2026 payment determination and subsequent years.

Table 128: Finalized Hospital OQR Program Measure Set For the CY 2026 Payment Determination

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)
0499	Left Without Being Seen†
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
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	Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (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 Infraction (STEMI) electronic clinical quality measure (eCQM)*****

†CMS notes that CBE endorsement for this measure was removed.
** In this final rule, CMS is finalizing its proposal to modify the Colonoscopy Follow-Up Interval measure beginning with the CY 2024 reporting period/CY 2026 payment determination.*
*** In the CY 2023 OPPS/ASC final rule (87 FR 72097 through 72099), 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 final rule, CMS is finalizing its proposal 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 (86 FR 63840), 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 final rule, CMS is finalizing its proposal to modify the COVID–19 Vaccination Coverage Among HCP measure beginning with the CY 2024 reporting period/CY 2026 payment determination.*
****** The STEMI eCQM was adopted in the CY 2022 OPPS/ASC final rule (86 FR 63837 through 63840), 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 129, below, summarizes the previously finalized and newly finalized Hospital OQR Program measures beginning with the CY 2027 payment determination and subsequent years:

Table 129: Finalized 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)
0499	Left Without Being Seen†
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
3663	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 final rule, CMS is finalizing its proposal to re-adopt the HOPD Procedure Volume measure with modification beginning with the voluntary CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.
** In the CY 2023 OPPS/ASC final rule with comment period (87 FR 72097 through 72099), CMS finalized keeping data collection and submission voluntary for this measure for the CY 2025 reporting period and subsequent years.
***In this final rule, CMS is finalizing its proposal to adopt the THA/TKA PRO–PM beginning with the voluntary CY 2025 reporting period and with delayed implementation of mandatory reporting beginning with the CY 2028 reporting period/CY 2031 payment determination.
****In this final rule, CMS is finalizing its proposal to adopt the Excessive Radiation eCQM beginning with the voluntary CY 2025 reporting period and with delayed implementation of mandatory reporting beginning with the CY 2027 reporting period/CY 2029 payment determination.

XV. REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM (Page 1,174)

Modifications to Previously Adopted Measures (Page 1,177)

CMS propose 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. CMS is finalizing its proposed modification to the COVID–19 Vaccination Coverage Among HCP Measure as proposed. (Page 1,192)

(2) Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure survey instrument use. CMS is finalizing its proposal to modify the Cataracts Visual Function measure as proposed. (Page 1,202)

(3) Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure. CMS is finalizing its proposal to modify the Colonoscopy Follow-Up Interval measure as proposed. (Page 1,206)

Adoption of New Measures for the ASCQR Program Measure Set (Page 1,206)

CMS proposed 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. CMS is NOT finalizing its proposal to re-adopt with modification the ASC Procedure Volume measure. (Page 1,226)

(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. CMS is finalizing adoption of the THA/TKA PRO–PM into the ASCQR Program. (Page 1,252)

ASCQR Program Quality Measure Set (Page 1,252)

The rule's table 139 summarizes the previously finalized ASCQR Program measure set for the CY 2024 reporting period/ CY 2026 payment determination.

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 #	NQF #	Measure Name
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 final rule, CMS is finalizing its proposal to standardize the surveys offered to patients pre- and post-surgery beginning with the CY 2024 reporting period/CY 2026 payment determination.
** In this final rule, CMS is finalizing its proposed modification 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 140 summarizes the previously finalized and newly proposed ASCQR Program measures for the CY 2025 reporting period/CY 2027 payment determination. (Page 1,253)

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 on Selected ASC Surgical Procedures)**
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 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 Healthcare P Providers 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 #	NQF #	Measure Name
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.
** In this final rule, CMS is not finalizing its proposal to re-adopt 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.
*** In this final rule, CMS is finalizing its proposal 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 2028 reporting period/CY 2031 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.

XVI. REQUIREMENTS FOR THE RURAL EMERGENCY HOSPITAL QUALITY REPORTING (REHQR) PROGRAM (Page 1,274)

CMS has adopted it proposed 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.

XVII. CHANGES TO COMMUNITY MENTAL HEALTH CENTER (CMHC) CONDITIONS OF PARTICIPATION (COPS) (Page 1,354)

The CAA, 2023 established coverage of an intensive outpatient program (IOP) in CMHCs beginning January 1, 2024, Additionally, the CAA, 2023 established a new Medicare benefit category for Marriage and Family Therapists (MFT) services and Mental Health Counselor (MHC) services.

To implement these provisions CMS is finalizing, as proposed, to modify the requirements for the CMHC to include IOP services throughout the CoPs. CMS is also finalizing its proposal to modify the CMHC CoPs for personnel qualifications to add a definition of marriage and family therapists and revise the current definition of mental health counselors. CMS is also finalizing the addition of MFTs and MHCs to the list of practitioners who can lead interdisciplinary team meetings when deemed necessary.

Comment
The following 2 items simply identify issues previously described

XVIII. UPDATES TO REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES (Page 1,366)

XIX. CHANGES TO THE INPATIENT PROSPECTIVE PAYMENT SYSTEM MEDICARE CODE EDITOR (Page 1,498)

FINAL THOUGHTS
As previously noted, this analysis does not and cannot include all material expressed in the rulemaking. The rule is simply too long. The material keeps growing each year with the inclusion of unneeded and redundant history. CMS should explain its need to constantly repeat so much prior rulemaking on a subject.

Last year's final rule clocked in at 1,561 pages. This year's is 1,672. This is an increase of over 100 pages, an increase of more than 7.0 percent.

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

The reader should not overlook CMS' Economic Analyses starting on Page 1,575. CMS devotes much attention to the costs of the changes being made.

According to the Adobe program's word count, we note that CMS says appreciate or appreciated more than 550 times in response to commenters suggestions. Further, CMS has said thank(s) 200 times.

It is apparent that CMS' responses to comments, especially favorable responses, does not report on the number of unfavorable responses. Perhaps a better indication of comments and their impact on final decisions would be to provide such.