SUMMARY OF PROPOSED RULE – AUGUST 2023

CY 2024 Outpatient Prospective Payment System

Overview

In the July 31 *Federal Register,* the Centers for Medicare & Medicaid Services (CMS) published a proposed rule providing updates and policy changes to the Medicare outpatient prospective payment system (OPPS) for calendar year (CY) 2024. The proposed policy and payment provisions — if finalized — are generally effective for CY 2024 services, beginning Jan. 1, 2024.

The following is a comprehensive summary of the proposed rule's acute care hospital provisions. In addition to annual payment and quality updates, the summary details policies related to the inpatient-only list, payment for separately payable drugs acquired under the 340B program, additional price transparency requirements, and a request for information related (RFI) to add-on payments for maintaining stockpiles of pharmaceuticals that are subject to shortage.

The proposed rule also includes provisions for ambulatory surgical centers (ASCs). For a detailed summary of those provisions, please contact cmulvany@calhospital.org.

For Additional Information

Questions about this summary should be directed to Megan Howard, vice president of federal policy, at (202) 488-3742 or mhoward@calhospital.org; or Chad Mulvany, vice president of federal policy, at (202) 270-2143 or cmulvany@calhospital.org. Facility-specific CHA DataSuite analyses were sent under separate cover. Questions about CHA DataSuite should be directed to Alenie Reth, data analytics coordinator, at areth@calhospital.org.

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Summary of Key Provisions

The proposed rule includes annual updates to the Medicare fee–for–service (FFS) outpatient payment rates as well as regulations that implement new policies. The rule proposes policies that will:

- Increase the market basket by 2.8%
- Add 10 services from the inpatient-only (IPO) list
- Expand the partial hospitalization program (PHP) rate structure
- Establish an intensive outpatient program (IOP)
- Standardize the reporting of standard chart data using a CMS template
- Outline quality program requirements for rural emergency hospitals (REHs)
- Update the requirements for the Hospital Outpatient Quality Reporting (OQR) Program

The proposed rule and other resources related to the OPPS are available on the CMS website. Comments are due to CMS by Sept. 11, and can be submitted electronically using the website's search feature for "CMS-1786–P."

The proposed increase in OPPS spending due only to changes in the 2024 OPPS rule is estimated to be approximately $1.92 billion. Considering estimated changes in enrollment, utilization, and case mix for 2024, CMS estimates that OPPS expenditures, including beneficiary cost-sharing, will be approximately $88.6 billion, which is approximately $6 billion higher than estimated OPPS expenditures in 2023.

CY 2024 Proposed OPPS Payment Update

Unlike in prior years due to COVID-19, CMS is using the most up-to-date claims data and cost report data (one year behind claims data) to set OPPS rates for the upcoming year. CMS is proposing to use CY 2022 claims data and CY 2021 Healthcare Cost Report Information System data from the December 2022 extract.

The tables below show the proposed CY 2024 conversion factor compared to final CY 2023 and the components of the update factor:

	Final CY 2023	Proposed CY 2024	Percent Change
OPPS Conversion Factor	$85.585	$87.488	++2.22%

Proposed CY 2024 Update Factor Component	Value
Market Basket Update	+3.0%
Affordable Care Act (ACA)–Mandated Productivity	–0.2 percentage points (PPT)
Wage Index Budget Neutrality (BN) Adjustment	+0.26%
Wage Index 5% Stop Loss BN	-0.25%
Pass–Through Spending/Outlier BN Adjustment	-.10%
Cancer Hospital BN Adjustment	+0.05%
Overall Proposed Rate Update	**+2.22%**

CMS estimates the proposed update to the conversion factor net of the total factor productivity (TFP) will increase payments 2.8% in 2024 (market basket of 3%, less 0.2% for TFP).

CMS notes the following estimated impacts in Table 100 of the proposed rule:

Facility Type	Estimated 2024 Impact (Proposed)
All Hospitals	3%
Urban – All	2.8%
Urban – Pacific Region	5.8%
Rural – All	4.4%
Rural – Pacific Region	7%

California estimated impacts provided by CHA DataSuite are noted in the table below; impacts will vary by hospital.

OPPS CY 2024 Proposed Rule Analysis
CY 2024 Proposed Rule Compared to CY 2023 Final Rule

California

Impact Analysis	Dollar Impact	% Change
Estimated CY 2023 OPPS Payments	*$6,203,376,000*	
Marketbasket Update	$148,392,700	2.39%
ACA-Mandated Productivity Adjustment	($9,893,900)	-0.16%
Budget Neutrality Adjustments	($28,519,200)	-0.46%
Wage Index (Removal of Previous Bottom Quartile and Stop Loss (including rural floor))	($418,700)	-0.01%
Wage Index (Removal of Previous Rural Floor BN)	$28,403,900	0.46%
Wage Index (Removal of Previous Rural Floor Wage Index)	($37,185,000)	-0.60%
Wage Index (Change due to WI and LS prior to rural floor)	$27,020,400	0.44%
Wage Index (Current Rural Floor Wage Index Added)	$322,579,000	5.20%
Wage Index (Current Rural Floor Budget Neutrality Added)	($72,119,500)	-1.16%
Increasing Bottom Quartile Wage Index Values	$0	0.00%
Wage Index 5% Stop Loss	$6,642,600	0.11%
Change in Rural Add-On	$0	0.00%
APC Factor/Updates	$53,632,300	0.86%
Estimated CY 2024 OPPS Payments	*$6,641,910,600*	
Total Estimated Change From CY 2023 to CY 2024	**$438,534,600**	**7.07%**

The values shown in the table above do not include the 2.0% sequestration impact to all lines of Medicare payment authorized by Congress through FFY 2032. It is estimated that sequestration will reduce CY 2024 OPPS-specific payments by: $132,838,200

Source: CHA DataSuite Analysis, August 2023

Updates Affecting OPPS Payments

Recalibration of APC Relative Payment Weights

As required by law, CMS must review and revise the ambulatory payment classification (APC) relative payment weights annually. CMS must also revise the APC groups each year to account for drugs and medical devices that no longer qualify for pass-through status, new and deleted Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, advances in technology, new services, and new cost data. The proposed payment weights and rates for CY 2024 are available in Addenda A and B on the CMS website.

The table below shows the shift in the number of APCs per category from CY 2023 to CY 2024 (Addendum A):

APC Category	Status Indicator	Final CY 2023	Proposed CY 2024
Pass–Through Drugs and Biologicals	G	96	75
Pass–Through Device Categories	H	12	7
OPD Services Paid through a Comprehensive APC	J1	69	71
Observation Services	J2	1	1
Non–Pass–Through Drugs/Biologicals	K	389	469
Partial Hospitalization	P	2	8
Blood and Blood Products	R	40	40
Procedure or Service, No Multiple Reduction	S	82	82
Procedure or Service, Multiple Reduction Applies	T	28	28
Brachytherapy Sources	U	17	17
Clinic or Emergency Department Visit	V	11	11
New Technology	S/T	112	112
Total		**859**	**921**

Blood and Blood Products

For CY 2024, CMS proposes continuing its policy to establish payment rates for blood and blood products using a blood-specific, cost-to-charge ratios methodology.

Brachytherapy Sources

Since 2010, CMS has used the standard OPPS payment methodology for brachytherapy sources, with payment rates based on source-specific costs as required by statute. CMS does not propose changes to its brachytherapy policy for 2024. If CMS does not have billing data to set the payment rates, it may use external data to set prices for brachytherapy sources. For 2018 through

2023, CMS used external data to set a payment rate for HCPCS code C2645 (brachytherapy planar source, palladium-103, per square millimeter) at $4.69 per mm^2. CMS has three 2022 claims for HCPCS code C2645 to set a rate for 2024. The geometric mean cost is $168.67. The proposed rule indicates that CMS is unable to use these claims for rate-setting purposes given the reporting of only one unit per claim and the high geometric mean cost. For this reason, CMS proposes to use its equitable adjustment authority under section 1833(t)(2)(E) to continue the rate of $4.69 per mm^2 for 2024 for HCPCS code C2645.

Comprehensive APCs (C-APCs)

A C-APC covers payment for all Part B services that are related to the primary procedure, including items currently paid under separate fee schedules. The C-APC encompasses diagnostic procedures, lab tests, and treatments that assist in the delivery of the primary procedure; visits and evaluations performed in association with the procedure; coded and un-coded services and supplies used during the service; outpatient department services delivered by therapists as part of the comprehensive service; durable medical equipment as well as the supplies to support that equipment; and any other components reported by HCPCS codes that are provided during the comprehensive service. The costs of blood and blood products are included in the C-APCs when they appear on the same claim as those services assigned to a C-APC.

The C-APCs do **not** include payments for services that are not covered by Medicare Part B, nor those that are not payable under OPPS, such as:

- Certain mammography and ambulance services
- Brachytherapy sources
- Pass-through drugs and devices
- Charges for self-administered drugs
- Certain preventive services
- Procedures assigned to a New Technology APC either included on a claim with a "J1" or when packaged into payment for comprehensive observation services assigned to status indicator "J2" when included on a claim with a "J2" indicator

CMS is proposing to create two C-APCs for CY 2024 for a total of 72 C-APCs by proposing to split the Level 2 Intraocular APC (APC 5492) into two and assign the higher cost procedures previously within this APC to a new Level 3 Intraocular APC (APC 5493). The previous Level 3, Level 4, and Level 5 Intraocular APCs (APCs 5493, 5494, and 5495) will be renamed the Level 4, Level 5, and Level 6 Intraocular APC (APCs 5494, 5495, and 5496), respectively. Separately, CMS is proposing to add a new Level 2 Abdominal/Peritoneal/Biliary and Related Procedures APC (APC 5342) to improve clinical and resource homogeneity in the Level 1 Abdominal/Peritoneal/Biliary and Related Procedures APC (APC 5341). The proposed C-APCs derived from the new APCs are:

- Level 2 Abdominal/Peritoneal/Biliary and Related Procedures (C-APC 5342)
- Level 6 Intraocular Procedures (C-APC 5496)

A list of the proposed 72 C–APCs for CY 2024 C-APCs can be found in Table 1.

Calculation of Composite APC Criteria-Based Costs

Composite APCs are another type of packaging to provide a single APC payment for groups of services that are typically performed together during a single outpatient encounter. Currently, there are six composite APCs for:

- Mental Health Services (APC 8010)
- Multiple Imaging Services (APCs 8004, 8005, 8006, 8007, and 8008)

For CY 2024, CMS proposes continuing its policy on aggregate payments for specified mental health services provided by a hospital to a single beneficiary on a single date of service. In that circumstance, when a payment exceeds the maximum per diem payment rate for partial hospitalization services, those services will continue to instead be paid through composite APC 8010. In addition, the payment rate for composite APC 8010 will continue to be set to that established for APC 5863, which is a partial hospitalization per diem payment rate for three partial hospitalization services furnished in a day by a hospital.

CMS notes that APC 5863 would no longer be the maximum partial hospitalization per diem payment rate for a hospital, due to proposed APC 5864 (four or more hospital-based partial hospitalization services per day), but still believes that APC 5863 is appropriate. However, since CMS has historically set the daily mental health cap for APC 8010 at the maximum partial hospitalization per diem payment rate or a hospital, CMS is soliciting feedback on whether proposed APC 5864 should be used instead.

For CY 2024, CMS is also proposing to continue its current composite APC payment policies for multiple imaging services from the same family and on the same date. Table 2 includes the HCPCS codes that are subject to the multiple imaging procedure composite APC policy and their respective families, as well as each family's geometric mean cost.

Universal Low-Volume APCs Payment Policy

For CY 2024, CMS proposes continuing the universal low-volume APC payment methodology for services assigned to new technology, clinical, and brachytherapy APCs with fewer than 100 claims. This policy uses the highest of the geometric mean, arithmetic mean, or median based on up to four years of claims data to set the payment rate for the APC.

Changes to Packaged Items and Services

CMS is not proposing any changes to its packaging policies and separate payment for nonopioid treatment alternatives. However, the proposed rule indicates that section 4135(a) and (b) of the Consolidated Appropriations Act (CAA), 2023 prohibit packaged payment and require separate payment for nonopioid pain relief treatments from Jan. 1, 2025, through Dec. 31, 2027. CMS will include proposals to implement this CAA provision in the 2025 OPPS rule. While CMS expects this policy to operate similarly in the ASC and hospital outpatient department (HOPD) settings, CMS welcomes comment on whether there are any HOPD-specific payment issues it should take into consideration when planning to implement this provision for 2025.

Wage Index Changes

CMS proposes to continue using a labor share of 60% and the fiscal year inpatient prospective payment system (IPPS) post-reclassified wage index for the OPPS in CY 2024. In the federal fiscal year (FFY) 2023 IPPS rule, CMS applied a 5% cap on reductions to a hospital wage index for any

reason. CMS proposes to continue this same policy under the OPPS for CY 2024. CMS makes this change in a budget-neutral manner, necessitating a -0.25% budget-neutrality adjustment to the conversion factor.
For non-IPPS hospitals paid under the OPPS for CY 2024, CMS proposes continuing its past policies of assigning the wage index that would be applicable if the hospital were paid under the IPPS and allowing the hospital to qualify for the out-migration adjustment.

Due to litigation determining that the secretary does not have the authority to establish a rural floor lower than the rural wage index floor in a state, in the FFY 2024 IPPS proposed rule, CMS proposed to treat §412.103 (redesignated rural) hospitals the same as geographically rural hospitals for the rural wage index calculation, including those hospitals with other reclassifications.

Additionally, CMS has a longstanding hold harmless policy to prevent the rural wage index of a state from being lowered by hospitals that reclassify to a state's rural area. Due to the proposal above, the rural wage index would no longer be held harmless from in-state hospitals reclassifying as rural under §412.103. However, for hospitals that have a state-to-state MGCRB reclass, in the FFY 2024 IPPS proposed rule, CMS proposed to continue this hold harmless policy to exclude the data of hospitals reclassifying into another state's rural area, if doing so would reduce that state's rural wage index.

In order to address wage index disparities between high- and low-wage index hospitals, CMS made a variety of changes that would affect the wage index and wage index-related policies in the FFY 2020 IPPS final rule. CMS is proposing to continue increasing the wage index for hospitals within the bottom quartile of the nation by a value equivalent to half of the difference between the hospital's pre-adjustment wage index and the 25th percentile wage index value across all hospitals. CMS proposes continuing to offset these increases by applying a budget-neutrality adjustment to the national standardized amount. In the FFY 2024 IPPS proposed rule, the value of the 25th percentile wage index is 0.8615.

CMS notes that this policy is subject to pending litigation (*Bridgeport Hospital, et al., v. Becerra*) in which the court found that the secretary did not have the authority to adopt this low-wage index policy and has ordered additional briefing on an appropriate remedy. This court decision involves only FFY 2020, is not final, and has been appealed by CMS.

CMS is proposing a wage index and labor-related share budget-neutrality factor of 0.9974 for CY 2024 to ensure that aggregate payments made under the OPPS are not greater or less than would otherwise be made if wage index adjustments had not changed. CMS is also proposing a separate budget-neutrality factor of 0.9975 for the impact of the 5% cap on wage index decreases.

Sole Community Hospital (SCH) Adjustment

For CY 2024, CMS proposes continuing to apply a 7.1% payment adjustment for rural sole community hospitals — including essential access community hospitals — for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs. The adjustment is budget-neutral and is applied before calculating outliers and copayments.

Cancer Hospital Adjustment

CMS proposes continuing payment increases to the 11 exempt cancer hospitals. CMS does this by providing a payment adjustment so that the cancer hospital's target payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals (and thus the adjustment is budget neutral).

CMS proposes a target PCR equal to 0.88 for each cancer hospital. CMS reduced the CYs 2020 through 2023 PCR of 0.89 (which included the application of the 1.0 percentage point reduction mandated by the 21st Century Cures Act) by an additional 1.0 percentage point. CMS proposes that this policy will apply for CY 2024 and subsequent years, until the target PCR equals the PCR of non-cancer hospitals calculated using the most recent data minus 1.0 percentage points as required by the 21st Century Cures Act. Therefore, CMS is proposing a 0.05% adjustment to the CY 2024 conversion factor to account for this policy.

Table 5 in the proposed rule shows the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals, with increases in OPPS payments for 2024 ranging from 11.6% to 56.9%. CMS indicates that the reduction in the cancer hospital adjustment requires a budget-neutrality adjustment of 0.05%.

Outpatient Outlier Payments

To maintain total outlier payments at 1% of total OPPS payments, CMS proposes using CY 2022 claims to calculate a CY 2024 outlier fixed-dollar threshold of $8,350. This is a 3.2% decrease compared with the current threshold of $8,625. Outlier payments will continue to be paid at 50% of the amount by which the hospital's cost exceeds 1.75 times the APC payment amount when both the 1.75-multiplier threshold and the fixed-dollar threshold are met.

New Technology APCs

Currently, there are 52 levels of New Technology APC groups with two parallel status indicators: one set with a status indicator of "S" (S = Significant procedure, not discounted when multiple) and the other set with a status indicator of "T" (T = Significant procedure, multiple reduction applies). The New Technology APC levels range from the cost band assigned to APC 1491 (New Technology – Level 1A [$0 - $10]) through the highest cost band assigned to APC 1908 (New Technology – Level 52 [$145,001 - $160,000]). The proposed payment rates for these New Technology APCs are included in Addendum A to this proposed rule.

Pass-Through Payments for Devices

There are currently 15 device categories proposed to be eligible for pass-through payment. Table 28 (reproduced below) lists the devices and their pass-through expiration.

Table 28: Devices with Pass-Through Status Expiring in the Fourth Quarter of 2023, 2024 or 2025

HCPCS Codes	Long Descriptor	Effective Date	Pass-Through Expiration Date
C1824*	Generator, cardiac contractility modulation (implantable)	1/1/2020	12/31/2022

Table 28: Devices with Pass-Through Status Expiring in the Fourth Quarter of 2023, 2024 or 2025			
HCPCS Codes	**Long Descriptor**	**Effective Date**	**Pass-Through Expiration Date**
C1982*	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2022
C1839*	Iris prosthesis	1/1/2020	12/31/2022
C1734*	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2022
C2596*	Probe, image-guided, robotic, waterjet ablation	1/1/2020	12/31/2022
C1052	Hemostatic agent, gastrointestinal, topical	1/1/2021	12/31/2023
C1062	Intravertebral body fracture augmentation with implant	1/1/2021	12/31/2023
C1825	Generator, neurostimulator (implantable) non-rechargeable with carotid sinus baroreceptor simulation lead(S)	1/1/2021	12/1/2023
C1761	Catheter, transluminal intravascular lithotripsy, coronary	7/1/2021	6/30/2024
C1831	Personalized, anterior and lateral interbody cage (implantable)	10/1/2021	9/20/2024
C1832	Autograft suspension, including cell processing and application, and all system components	1/1/2022	12/31/2024
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	1/1/2022	12/31/2024
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	1/1/2023	12/31/2025
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	1/1/2023	12/31/2025
C1747	Endoscope, single-use (i.e., disposable) urinary tract, imaging/illumination device (insertable)	1/1/2023	12/31/2025
*Device for which pass-through status was extended for a 1-year period by section (a)(2) of the CCA, 2023.			

New Device Pass-Through Applications

CMS has received six applications for device pass–through payment applications since the March 1, 2023, quarterly deadline. They include:

- CavaClear Inferior Vena Cava (IVC) Filter Removal Laser Sheath
- CERAMENT® G
- Ambu® aScopeTM 5 Broncho HD
- Praxis Medical CytoCore
- EchoTip®
- FLEX Vessel Prep™ System

Device-Intensive Procedures

Device-Intensive Procedure Policy for 2019 and Subsequent Years

Device-intensive APCs are procedures that require the implantation of a device and are assigned an individual HCPCS code-level device offset of more than 30% of the procedure's mean cost, regardless of APC assignment.

For CY 2024, CMS is not proposing any changes to the device-intensive policy. The full list of 2024 device-intensive procedures is provided in Addendum P.

Device Edit Policy

CMS is proposing to continue to require claim processing edits when any of the device codes used in the previous device-to-procedure edits are present on the claim with a device-intensive procedure that includes the implantation of a device. CMS previously created HCPCS code C1889 (implantable/insertable device, not otherwise classified) to recognize devices used during device–intensive procedures that are not described by specific Level II HCPCS Category C-Code. This HCPCS code satisfies the edit requirement.

CMS believes that procedures associated with Level 5 Intraocular APC (which CMS proposes to reassign to a new Level 6 Intraocular APC 5496) would benefit from a procedure-to-device edit because payment stability for this Low Volume APC relies on accurate reporting of the procedure's associated costs. Therefore, CMS is proposing a procedure-to-device edit for the procedures assigned to APC 5496, listed below:

- CPT code 0308T (Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis) describes the implantation of device HCPCS code C1840 (Lens, intraocular (telescopic))
- CPT code 0616T (Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens) describes the implantation of device HCPCS code C1839 (Iris prosthesis)
- CPT code 0308T (Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis) describes the implantation of device HCPCS code C1840 (Lens, intraocular (telescopic))
- CPT code 0616T (Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens) describes the implantation of device HCPCS code C1839 (Iris prosthesis)

Hospitals would be required to report the correct device HCPCS codes when reporting any of the above procedures.

Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices

For outpatient services that include certain medical devices, CMS reduces the APC payment if the hospital received a credit from the manufacturer. The offset can be 100% of the device amount when a hospital attains the device at no cost or receives a full credit from the

manufacturer, or 50% when a hospital receives partial credit of 50% or more. For CY 2024, CMS is not proposing any major changes to the no-cost/full credit and partial credit device policies.

Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

CMS pays for drugs and biologicals that do not have pass-through status in one of two ways: either packaged into the APC for the associated service or assigned to their own APC and paid separately. The determination is based on the packaging threshold. CMS allows for a quarterly expiration of pass-through payment status of drugs and biologicals newly approved to grant a pass-through period as close to three full years as possible, and to eliminate the variability of the pass-through payment eligibility period without exceeding the statutory three-year limit.

For CY 2024, CMS proposes a packaging threshold of $140. Drugs, biologicals, and radiopharmaceuticals that are above the $140 threshold are paid separately, using individual APCs, and those below the threshold are packaged; the baseline payment rate for CY 2024 is the average sales price (ASP) +6%.

CMS will continue paying for separately payable drugs and biological products that do not have pass-through status and are not acquired under the 340B program at wholesale acquisition cost (WAC) +3%, instead of WAC +6%.

For CY 2024, CMS continues paying for therapeutic radiopharmaceuticals with pass-through payment status as well as blood clotting factors, based on ASP +6%. If ASP data are not available, payment instead will be made based on WAC +3%, or 95% of average wholesale price (AWP) if WAC data are also not available.

The proposed rule expresses concern that packaging biosimilars when the reference biological or other marketed biosimilar are separately paid may create financial incentives for providers to select more expensive, but clinically similar, products. In response, CMS proposes that beginning with CY 2024, biosimilars would be exempt from the OPPS threshold packaging policy when their reference biologicals are separately paid (CMS would be paid separately for these biosimilars even if their per-day cost is below the packaging threshold). If a reference product's per-day cost falls below the threshold, CMS proposes that all the biosimilars related to the reference product would be similarly packaged regardless of whether their per-day costs are above the threshold in order to have consistent treatment of similar biological products.

Lastly, CMS is proposing that the pass–through status expire by Dec. 31, 2023, for 43 drugs and biologicals listed in Table 35; by Dec. 31, 2024, for 25 drugs and biologicals listed in Table 36; and proposing to continue/establish pass-through status in CY 2024 to 42 drugs and biologicals shown in Table 37.

OPPS Payment Methodology for 340B-Purchased Drugs

CMS proposes a rate of ASP +6% for 340B drugs in CY 2024, regardless of whether the product was acquired through the 340B program. If ASP data are not available, payment instead would be made based on WAC +3%; or 95% of AWP if WAC data are also not available.

In July 2023, CMS published a "remedy proposed rule" to address the reduced payment amounts to 340B hospitals under the reimbursement rates in the CYs 2018 through 2022 OPPS final rules. The remedy proposed rule does not propose changes to CY 2024 OPPS drug payment policies nor the conversion factor but does propose changes to the calculation of the OPPS conversion factor beginning in CY 2025. For additional information, please refer to CHA's executive and detailed summaries of the proposed remedy.

In CY 2023, modifiers "JG" and "TB" still applied for informational purposes but had no effect on payment rates. Modifier "JG" was used by non-exempt hospitals to report separately payable drugs that were acquired through the 340B program. Modifier "TB" was used by hospitals **exempt** from the 340B payment adjustment to report separately payable drugs that were acquired through the 340B program. These exempt hospitals include rural SCHs, children's hospitals, PPS–exempt cancer hospitals, and PPS-exempt critical access hospitals (CAHs).

CMS now believes using a single modifier will allow for greater simplicity. Also, both modifiers are currently used to identify separately payable drugs and biologicals acquired under the 340B program. Therefore, CMS is proposing to only require a single modifier "TB" for 340B covered entities, effective Jan. 1, 2025. The "JG" would remain effective through Dec. 31, 2024, if a hospital desires to use it.

High/Low-Cost Threshold for Packaged Skin Substitutes

CMS divides skin substitutes into a *high-cost* group and a *low-cost* group in terms of packaging. CMS assigns skin substitutes with a geometric mean unit cost (MUC) or a products per day cost (PDC) that exceeds either the MUC threshold or the PDC threshold to the *high-cost* group.

CMS proposes to continue assigning those skin substitutes that did not exceed the thresholds but were assigned to the high-cost group in CY 2023 to the high-cost group in CY 2024 as well. CMS will also assign those with pass-through payment status to the high-cost category.

The list of proposed packaged skin substitutes and their group assignments may be found in Table 41.

Hospital Outpatient Visits

For CY 2024, CMS proposes that excepted off-campus PBDs of rural SCHs be exempt from the clinic visit payment policy because CMS believes that the volume of the clinic visit service in these hospitals is driven by factors other than the payment differential for the service. These hospitals would continue to bill HCPCS code G0463 with modifier "PO" but CMS would pay these hospitals the full OPPS payment rate.

For all other excepted off-campus PBDs, CMS proposes continuing to pay 40% of the OPPS rate for basic clinic services in CY 2024. These excepted PBDs continue to bill HCPCS code G0463 with modifier "PO."

Separately, CMS solicits comments on whether it would be appropriate to apply a different methodology for calculating PHP and IOP rates for nonexcepted off-campus HOPDs. Also, for CY 2024, CMS solicits comments on the current clinic and emergency department hospital

outpatient visits payment policies and the payment policy for critical care services when these services are provided on the campus of a hospital.

Finally, CMS observed that paying for ICR at a physician fee schedule (PFS)-equivalent rate has produced an anomalous result of ICR being paid at $120.47 in on-campus hospital departments, excepted off-campus PBDs, and physician offices but $48.03 in a non-excepted off-campus PBD in 2023. CMS indicates that this disparity creates a significant barrier to beneficiary access to an already underutilized service. This result is arguably inconsistent with intent of the applicable statutory provisions— to remove the significant payment disparity for the same services, depending on whether they are furnished in a physician's office or an off-campus, non-excepted PBD of a hospital. Therefore, beginning Jan. 1, 2024, CMS is proposing to pay for ICR services provided by an off-campus, non-excepted PBD of a hospital at 100% of the OPPS rate for cardiac rehabilitation services, rather than 40% of the OPPS rate.

Inpatient-Only (IPO) List

The IPO list specifies services/procedures that Medicare will pay for only when provided in an inpatient setting. For CY 2024, CMS is not proposing to remove any of the following services from the IPO list. However, CMS is seeking feedback on whether the following services are appropriate to remove from IPO list:

- CPT code 43775 (Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy))
- CPT Code 43644 (Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and roux-en-y gastroenterostomy (roux limb 150 cm or less))
- 43645 (Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption)
- 44204 (Laparoscopy, surgical; colectomy, partial, with anastomosis)

At this time, CMS does not believe it has adequate information to determine whether these services can be safely performed in the HOPD setting for the Medicare population but requests information whether these services meet any of the five criteria to be removed from the IPO list.

Further, CMS proposes adding the following services to the IPO list:

- CPT X114T: Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed
- CPT 2X002: Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments
- CPT 2X003: Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments
- CPT 2X004: Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed
- CPT 619X1: Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)
- CPT 7X000: Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic

- CPT 7X001: Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report
- CPT 7X002: placement, manipulation of transducer, and image acquisition only
- CPT 7X003: interpretation and report only
- CPT 0646T: Transcatheter tricuspid valve implantation (ttvi)/replacement with prosthetic valve, ercutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed

The proposed measures that are to be added to the IPO list are in Table 47.

Request for Information on Establishing and Maintaining Access to Essential Medicines

CMS believes it may be appropriate to pay separately for the additional costs associated with establishing and maintaining access, including through contractual arrangement, to a buffer stock of essential medicines. These potential separate payments would be in addition to payment for the essential medicines themselves, whether that payment is bundled with other items or services, or the essential medicines are separately paid.

The proposed rule indicates that it is challenging to quantify these additional costs precisely based on currently available information. Thus, CMS could initially base the IPPS payment on the IPPS shares of the additional reasonable costs of a hospital to establish and maintain access to its buffer stock. The use of IPPS shares in this payment adjustment would be consistent with the use of these shares for the payment adjustment for domestic NIOSH-approved surgical N95 respirators.

Costs could include those incurred to hold essential medicines directly at the hospital or contractually with a distributor or wholesaler. A hospital would report these costs in the aggregate on its cost report to CMS. These costs would not include the costs of the essential medicine itself. This information could be used to calculate a Medicare payment to establish and maintain access to a buffer stock of these essential medicines. Payments would be in accordance with reasonable cost principles through a biweekly payment with reconciliation during settlement of the cost report.

CMS solicits public comments, which are included in Appendix I on a variety of additional considerations that would be associated with this policy. Based on review of comments received, CMS may finalize this beginning Jan. 1, 2024.

Updates to Hospital Requirements to Make Public Standard Charges

Section 2718(e) of the Public Health Service Act requires each hospital operating within the United States to make its standard charges publicly available. In the Hospital Price Transparency (HPT) final rule published Nov. 27, 2019, CMS adopted requirements for hospitals to make public their standard charges in two ways:

1. As a comprehensive machine-readable file (MRF)
2. In a consumer-friendly format

Changes to Requirements

Definitions: CMS proposes the following:

- "CMS template" means a CSV format or JSON schema that CMS makes available for purposes of compliance with the price transparency requirements.
- "Consumer-friendly expected allowed amount" means the average dollar amount that the hospital estimates it will be paid by a third-party payer for an item or service.
- "Encode" means to enter data items into the fields of the CMS template.
- "Machine-readable file" means a single digital file that is in a machine-readable format.

Affirming the Accuracy and Completeness of Standard Charge Information in the MRF: CMS proposes to require that each hospital affirm directly in its MRF (using a CMS template described below) that it has included all applicable standard charge information in its MRF as of the date in the MRF. By affirming its accuracy within the MRF itself, CMS believes the public will understand that blanks mean the hospital does not have a standard charge for that item or service.

Improving Standardization of MRF Formats and Data Elements: As part of its efforts to improve standardization, CMS is making the following proposals with respect to how information is presented in the MRF:

- *Encode, as Applicable, All Data Items in the MRF*: Require hospitals to encode, as applicable, all standard charge information corresponding to each required data element in their MRF.
- *Revise and Expand the Required Data Elements*: Require expansion of the data elements (or categories) of hospital charge information that must be in the MRF to include:
    - Hospital name(s), license number, location name(s) and addresses under the single hospital license to which the list of standard charges applies
    - The file version and most recent update to the standard charge information in the MRF
- *Data Elements Related to Types of Standard Charges*: Require hospitals to:
    - Consolidate standard charges (gross charge, payer-specific negotiated charge, de-identified minimum and maximum negotiated charge, and discounted cash price) into a single data element.
    - Require that the payer-specific negotiated charges be displayed by name of the third-party payer and plan(s), each indicated as a separate data element (for example, "payer name" and "plan name"). Hospitals may indicate plan(s) as categories (such as "all PPO plans") when the established payer-specific negotiated charges are applicable to each plan in the indicated category.
    - Require that hospitals indicate the contracting method they used to establish the payer-specific negotiated charge.
    - Require that hospitals indicate whether the payer-specific standard charge listed should be interpreted by the user as a dollar amount, percentage, or, if the standard charge is based on an algorithm, the algorithm that determines the dollar amount for the item or service.
    - Post an "expected allowed amount" where the payer-specific negotiated charge cannot be expressed as a dollar figure such as when the expected payment is based on an algorithm. The expected allowed amount, also called the "consumer-friendly expected amount," may represent reimbursement for an average patient and is an amount that can be used to compare prices across hospitals.

- *Data Elements Related to Hospital Items and Services*: Requires hospitals to:
    - Indicate whether the item or service is connected to an inpatient admission or outpatient department visit.
    - For drugs, indicate the drug unit and type of measurement as separate data elements.
- *Data Elements Related to Item or Services Billing*: Require hospitals to specify any relevant modifiers that would change the standardized charge and its relevant code (HCPCS, CPT, APC, DRG, etc.) that it is modifying.
- *Specify Formatting Requirements*:
    - Requires hospitals to conform their formatting with CMS' template layout, data, specifications and data dictionary, to be provided through separate technical instructions. Layouts could be done in (1) JSON schema (plain format), (2) CSV ("wide" format), and (3) CSV ("tall" format).
    - Not conforming to CMS' template layout, data specifications, and data dictionary would be determined to be noncompliant and could be subject to a compliance action (although CMS reiterates that the presence of blanks for some data elements does not necessarily mean the hospital is non-compliant with the requirement).
    - Allow for a 60-day enforcement grace period to conform with the CMS template layout and encoding of standard charge information of the newly proposed data elements.

Improving Accessibility of Hospital MRFs: As indicated above, this proposal would require hospitals to improve the accessibility of the MRFs by including a .txt file in the root folder. It would include a direct link to the MRF and a link in the footer on its website that links directly to the publicly available web page that hosts the link to the MRF.

Changes to Improve and Enhance Enforcement

In the proposed rule, CMS distinguishes "monitoring" hospital compliance — which may include evaluating complaints, reviewing an analysis of non-compliance or auditing hospitals' website — from "assessment," which is a formal evaluation of whether hospitals are in compliance with the price transparency requirements. CMS believe this distinction is necessary because monitoring can be used by anyone while a compliance assessment can only be done by CMS. The rule includes proposals for Improving Assessment of Hospital Compliance:

- Revising the regulation to indicate that CMS may conduct a compliance review of a hospital's standard charges information posted on a publicly available website
- Requiring an authorized hospital official to submit to CMS a certification to the accuracy and completeness of standard charge information posted in the MRF and for the hospital affirm within the MRF the accuracy and completeness of standard charge information
- Requiring submissions to CMS of additional documentation as may be necessary to assess hospital compliance

CMS further proposes:

- Requiring hospitals to acknowledge receipt of a warning notice
- Notifying the health system leadership of a compliance action so it may work with the hospital system leadership to address similar deficiencies for hospitals across the health system

- Indicating that it may publicize information on its website related to CMS' assessment of a hospital's compliance, any compliance actions taken against a hospital, the status of such compliance, and the outcome.

Alignment with Transparency in Coverage and No Surprises Act

CMS describes the Transparency in Coverage rule that requires most group health plans and issuers of group or individual health insurance coverage to disclose personalized pricing information for covered items and service to their participants, beneficiaries, and enrollees through an online consumer tool, or in paper form, upon request. The proposed rule also describes the No Suprises Act (NSA). The NSA contains many provisions to protect consumers from surprise medical bills and improve price transparency. CMS indicates NSA will help patients understand health care costs in advance of care and minimize unforeseen medical bills.

CMS is interested in hearing from the public how the HPT requirements can best support and complement the consumer-friendly requirements found in these other price transparency initiatives. CMS asks the public to respond to a number of specific questions — listed in Appendix II — on how the information required can be improved to help consumers make better informed decisions.

Partial Hospitalization Program and Intensive Outpatient Services

Partial hospitalization programs (PHPs) are intensive outpatient (IOP) psychiatric programs that provide outpatient services in place of inpatient psychiatric care. PHP services may be provided in either a hospital outpatient setting or a freestanding community mental health center (CMHC). PHP providers are paid on a per diem basis, with payment rates calculated using CMHC- or hospital-specific data. CMS proposes several changes to the PHP, including revisions to the PHP payment methodology and physician certification requirements.

In addition, the CAA of 2023 established a new Medicare benefit category forIOP services. They are furnished under a distinct and organized outpatient program of psychiatric services for individuals who have an acute mental illness, called an IOP.

IOP services are less intensive than PHP services and can be furnished by a hospital to its outpatients, a CMHC, a federally qualified health center (FQHC), or a rural health clinic (RHC). CMS proposes to establish payment and program requirements for IOP services beginning with CY 2024.

Proposed Revisions to PHP Physician Certification Requirements

The CAA of 2023 amended the definition of PHP services to services to require that a physician determine that a patient needs a minimum of 20 hours of PHP services per week. CMS proposes to amend the regulations to require the physician certification for PHP services to include a certification that the patient requires such services for a minimum of 20 hours per week after 18 days, with subsequent recertifications no less than every 30 days. CMS notes that it does not believe this proposal creates a new requirement for PHPs because of its longstanding 20-hour minimum weekly regulatory requirement at §410.43(c)(1) and its current requirements for recertification every 30 days at §424.24(e)(3)(ii).

IOP Scope of Benefits

CMS proposes to codify conditions and exclusions applicable to IOP services. IOP services must be (i) reasonable and necessary, (ii) reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and (iii) furnished under a physician certification and plan of care. CMS proposes to define IOP services as:

> "Intensive outpatient services mean 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. Intensive outpatient services are not required to be provided in lieu of inpatient hospitalization."

CMS notes that the lack of a requirement that IOP services be provided in lieu of inpatient hospitalization is a key distinguishing factor from PHP services.

CMS proposes to list items and services that would be covered IOP services, which mirror the scope of services for PHP services. Specifically, IOP services could include individual and group therapy; occupational therapy; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; drugs and biologicals; individualized activity therapies; family counseling; patient training and education; and diagnostic services.

CMS clarifies that Medicare covers PHP for the treatment of substance use disorder (SUD) and that services for the treatment of SUD and behavioral health generally are consistent with the statutory and regulatory definitions of PHP. It further clarifies that the terms "trained psychiatric nurses, and other staff trained to work with psychiatric patients," would include trained SUD nurses and other staff trained to work with SUD patients under PHP or IOP programs.

Consistent with the regulations for PHP services, CMS proposes to specify that the following services are separately covered and not paid as IOP services:

- Physician services
- Physician assistant services
- Nurse practitioner and clinical nurse specialist services
- Qualified psychologist services
- Services furnished to skilled-nursing facility residents

CMS proposes to establish patient eligibility criteria for IOP services generally consistent with the regulations for PHP services, except for the requirement that a patient require 20 hours of services per week. Specifically, IOP services are intended for patients who require at least nine hours per week of therapeutic services (per the plan of care), are likely to benefit from a coordinated program of services, require more than isolated sessions of outpatient treatment, do not require 24-hour care, have an adequate support system while not actively engaged in the program, have a mental health diagnosis, are not judged to be dangerous to self or others, have the cognitive and emotional ability to participate in the active treatment process, and can tolerate the intensity of the IOP program.

CMS proposes to add a reference to "intensive outpatient services" to the list of services that are covered as medical and other health services under Part B, when furnished as hospital or CAH services incident to a physician's professional services. CMS also proposes to codify the statutory

exclusion of IOP services from the outpatient mental health treatment limitation by stating that IOP services not directly provided by a physician are not subject to the outpatient mental health treatment limitation.

IOP Certification and Plan of Care Requirements

CMS proposes to mirror the PHP content of certification and plan of care treatment requirements for IOPs, with some exceptions as directed by the statute. For example, the content of certification would have to include documentation that the individual requires such services for a minimum of nine hours per week, with no requirement for the patient to need inpatient psychiatric care if the IOP services were not provided. Recertification of IOP services would have to occur no less than every 60 days, though CMS seeks comment on whether a shorter interval for the first recertification and for subsequent recertification for IOP patients would be appropriate. The physician's certification of the patient's need for either IOP or PHP services should be based on the physician's determination and whether the patient meets the IOP or PHP patient eligibility criteria, respectively.

Coding and Billing for PHP and IOP Services under the OPPS

To differentiate between IOP and PHP for billing purposes, CMS proposes to require hospitals and CMHCs to report condition code 92 on claims for IOP services. Hospitals would continue to report condition code 41 for PHP claims, and CMS proposes to begin requiring CMHCs to also report condition code 41 for PHP claims. CHA refers readers to Table 43 of the proposed rule, which lists the codes CMS proposes would apply for the full range of services that may be provided by PHPs and IOPs.

Proposed Payment Methodology for PHP and IOP

Beginning in CY 2024, CMS proposes to establish four separate PHP APC per diem payment rates: one for CMHCs for three-service days and another for CMHCs for four-service days, and one for hospital-based PHPs for three-service days and another for hospital-based PHPs for four-service days. CMS notes that the standard PHP day is typically four services or more per day, however, payment is provided for three services a day for extenuating circumstances when a beneficiary would be unable to complete a full day of treatment.

CMS proposes to continue to calculate CMHC payment rates based solely on CMHC claims to recognize differences in cost structures for different PHP providers. However, CMS is considering whether establishing a site-neutral payment for using data from all providers of IOP services would be more appropriate to increase access to mental health services.

CMS is also proposing to establish consistent coding and payment between the PHP and IOP benefits. Therefore, it is proposing to consider all OPPS data for PHP days and non-PHP days that include three services per day and four services per day. Additionally, CMS is proposing to establish four separate IOP APC per diem payment rates at the same rates proposed for PHP APCs.

The table below compares the final CY 2023 and proposed CY 2024 PHP and IOP payment rates:

	Final Payment Rate 2023	Proposed Payment Rate 2024	Percent Change
APC 5853: Partial Hospitalization (3+ services) for CMHCs	$142.70	$96.49	-32.38%
APC 5854: Partial Hospitalization (4+ services) for CMHCs	-	$151.36	-
APC 5851: Intensive Outpatient (3+ services) for CMHCs	-	$96.49	-
APC 5852: Intensive Outpatient (4+ services) for CMHCs	-	$151.36	-
APC 5863: Partial Hospitalization (3+ services) for Hospital-Based PHPs	$268.22	$280.80	+4.69%
APC 5864: Partial Hospitalization (4+ services) for Hospital–based PHPs	-	$364.04	-
APC 5861: Intensive Outpatient (3+ services) for Hospital–based IOPs	-	$280.80	-
APC 5862: Intensive Outpatient (4+ services) for Hospital–based IOPs	-	$364.04	-

With the addition of payment rates for four services per day based on cost per day using all OPPS data, CMS proposes not to apply PHP-specific trims and data exclusions, but instead to apply the same trims and data exclusions consistent with OPPS.

CMS proposes to continue to make outlier payments to CMHCs for 50% of the amount by which the cost for the PHP service exceeds 3.4 times the highest CMHC PHP APC payment rate implemented for that calendar year. As in prior years, CMS will apply an 8% outlier payment cap to the CMHC's total per diem payments. However, if the proposal to allow CMHCs to provide and bill for IOP services is adopted, CMS proposes to expand the calculation of the CMHC outlier percentage to include PHP and IOP.

IOP Services Provided in RHC and FQHC Settings

CMS generally proposes the same requirements for IOP services provided in RHCs and FQHCs that apply to hospital-based and CMHC programs, including the scope of benefits, standards for physician certification, and patient eligibility criteria.

The CAA of 2023 established payment rules for IOP services furnished by RHCs and FQHCs. Payment to these facilities for these services must equal the amount that would have been paid under Medicare for IOP services had they been covered outpatient department services furnished by a hospital.

CMS believes the payment for these services furnished by RHCs and FQHCs should be structured to be days with three or fewer services. It proposes the following payment rates:

- For RHCs, the rate determined for APC 5861 (IOP (three services per day) for hospital-based IOPs)
- For FQHCs, the lesser of a FQHC's actual charges or the rate determined for APC 5861.

- For grandfathered tribal FQHCs, payment would be based on the lesser of the FQHC's actual charges or the outpatient per visit rate.

CMS seeks comment on whether these proposed payment rates should be adjusted to reflect the variations in costs of furnishing services in different geographic areas and what approaches would be appropriate for determining the value of the adjustment. CMS also seeks comment on whether the hospital-based IOP APC 5862 for four-service days would be appropriate for RHCs and FQHCs.

CMS proposes to require RHCs and FQHCs to report condition code 92 to identify intensive outpatient claims for the list of proposed HCPCS codes included in Table 43. This is because, per the statute, they are paid for IOP services outside of the RHC all-inclusive rate methodology and FQHC PPS, respectively. Additionally, at least one service must be from the IOP Primary list (identified in Table 44 of the proposed rule).

The statute requires that costs associated with IOP services are not to be used to determine the amount of payment for FQHC services or RHC services. CMS proposes conforming changes to its regulations and says that revisions will be made to the cost reporting instructions to account for these changes. FQHCs that contract with Medicare Advantage (MA) organizations must be paid at least the same amount they would have received for the same service under the FQHC PPS, with Medicare making up the difference between the FQHC PPS payment rate and a lower MA payment rate. CMS proposes to apply the same policy for IOP services furnished by FQHCs.

CMS proposes to modify regulations to clarify that it will permit a mental health visit or IOP services on the same day as a medical visit. Generally, RHC and FQHC encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and a single location, constitute a single visit. However, there are exceptions for patients with a medical visit or physical exam visit and a mental health visit on the same day. However, an encounter cannot include a mental health visit and an IOP service on the same day.

Payment Rates in Non-Excepted Off-Campus Provider-Based Departments (PBDs)

As required by the Bipartisan Budget Act of 2015, PHP services furnished by nonexcepted off-campus PBDs are set at the rate equal to the CMHC payment rate for three or more PHP services per day. CMS proposes to use the CMHC rates for PHP and IOP as the payment rates for PHP and IOP services furnished by non-excepted off-campus HOPD; it would use the three services rate or the four-or-more services rate based on how many services the non-excepted off-campus PBD furnished on that day.

Mental Health Services Furnished to Patients in their Homes

In the CY 2023 OPPS final rule, CMS established three HCPCS C-codes for mental health services furnished by hospital staff to beneficiaries in their homes through communications technology. CMS did not specify whether the codes should be used for individual or group services, preferring to keep the coding more general until the agency had experience with these codes. In response to stakeholder input, CMS proposes to create a new, untimed, HCPCS C-code describing group therapy. CMS explicitly seeks comments on the descriptors of the remote group and individual psychotherapy codes to ensure they are sufficiently clear as to their use.

CHA refers readers to Table 50 in the proposed rule, which provides the proposed C-code and long descriptor for this new C-code. CMS proposes to assign this new C-code to APC 5821 that pays $28.62. This APC assignment was based on the facility PFS payment for a similar service (CPT code 90853 for group psychotherapy) to reflect CMS belief that the hospital has lower costs when providing a mental health service to a patient in the home than at the hospital.
CMS further proposes to modify the individual psychotherapy codes to remove the word "initial" from the descriptor to make clear that the codes can be used for an initial or subsequent encounter.

Finally, CMS proposes to delay its previously finalized policy that requires a patient receive an in-person visit within six months prior to the first time a mental health service is provided remotely. Additionally, there must be an in-person visit within 12 months of each mental health service furnished remotely by the hospital clinical staff, until Jan. 1, 2025, as required by the CAA of 2023.

Outpatient Therapy, Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT)

CMS proposes to retain physical and occupational therapists and speech-language pathologists as eligible telehealth distant site practitioners through the end of 2024, as required by the CAA of 2023. Notably, in the CY 2023 PFS proposed rule, CMS proposes to continue to make payment for outpatient therapy services, diabetes self-management training, and medical nutrition therapy when furnished via telehealth by qualified employed staff of institutional providers through the end of CY 2024. CHA refers readers to the summary of the PFS proposed rule for more information.

Supervision of Cardiac and Pulmonary Rehabilitation Services

Under current OPPS policy, cardiac, intensive cardiac, and pulmonary rehabilitation services (CR, ICR, and PR) must be provided under the direct supervision of a physician. CMS proposes to modify its regulations to allow CR, ICR and PR services to be furnished under the direct supervision of a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) — as required by the Bipartisan Budget Act of 2018 — beginning on Jan. 1, 2024.

For the duration the COVID-19 public health emergency, CMS adopted that for the purposes of direct supervision, a physician can be present virtually through audio/video real-time communications technology for PR, CR, and ICR services when the use of technology reduces exposure risks for the patient or the provider. As required by the CAA of 2023, CMS proposes to extend this policy through the end of CY 2024 and extend the authority for virtual supervision of these services to be furnished by PAs, NPs and CNS beginning Jan. 1, 2024.

Payment of Intensive Cardiac Rehabilitation in a Non-Excepted Off-Campus PBD

By statute, Medicare payment for ICR in a physician's office is equal to the payment rate for CR under the OPPS. However, CMS has observed that its policy to pay for services furnished in a non-excepted off-campus PBD at the PFS equivalent rate has resulted in an unintended reimbursement disparity between excepted and non-excepted sites of service. To address this, CMS proposes to pay for ICR services provided by an off-campus, non-excepted PBD of a hospital

at 100% of the OPPS rate for CR services, rather than 40% of the OPPS rate. This policy would apply to the HCPCS codes G0422 and G0423 for ICR with and without exercise respectively.

OPPS Payment for Dental Services

In the CY 2023 PFS final rule, CMS adopted policies rule to allow for payment for certain dental services performed in outpatient settings. However, the current dental codes assigned to APCs for 2023 do not fully describe the dental services that may be inextricably linked to covered medical services and payable under Medicare Part B. Only 57 Current Dental Terminology (CDT) codes are assigned to APCs in 2023. In the CY 2023 OPPS final rule, CMS created HCPCS code G0330 to describe facility services for dental rehabilitation procedure(s) furnished to patients who require monitored anesthesia and use of an operating room. This code cannot be used to describe or bill the facility fee for non-covered services.

For CY 2024, CMS proposes to assign 229 additional dental codes to clinical APCs to enable them to be paid for under the OPPS when payment and coverage requirements are met. The dental services for which CMS proposes APC assignments are those dental services for which Medicare Part B payment can be made when they are inextricably linked to other covered medical services. CMS is not proposing APC assignments for dental services that would not be paid under the OPPS because they describe only the service of a practitioner such as the services of a physician, PA, NP, CNS, or anesthetist that are not paid under the OPPS. CHA refers readers to Table 53 of the proposed rule for the list of dental codes proposed for assignment to APCs.

CMS proposes to package payments for dental services when they are performed with another covered dental or medical service consistent with its general OPPS packaging policies and refers readers to Addendum B for the proposed 2024 status indicators for dental codes.

Hospital OQR Program

The hospital OQR program is mandated by law; hospitals that do not successfully participate are subject to a 2-percentage point reduction to the OPPS market basket update for the applicable year. CMS posts the list of individual hospitals meeting or failing to meet OQR reporting requirements. For the CY 2023 payment determination, 3,020 of 3,297 hospitals (97.5%) met all reporting requirements — including data submission — while 77 failed to do so. CAHs may choose but are not required to report OQR measures.

CMS proposes several changes to the OQR measures set, including the removal of one measure, modification of three existing measures, re-adoption of a previously removed measure, and the adoption of two new measures, including one electronic clinical quality measure (eCQM). CMS also proposes policies related to public reporting of data for one measure and seeks comments on future measure topic areas including patient and workforce safety, behavioral health, and telehealth.

CMS makes no changes to previously finalized OQR program policies for:

- Measure selection, retention, and removal
- Data submission via the CMS web-based tool, the Centers for Disease Control and Prevention National Healthcare Safety Network tool

- The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey-Based Measures (OP-37a-e)
- eCQMs
- Population and sampling requirements
- The educational review and correction process for chart-abstracted measures
- Reconsideration and appeals procedures
- Public display of quality measures
- Requirements for participation in and withdrawal from the OQR program

A table in the appendix of this summary shows the previously and newly adopted OQR program measures for payment determinations from 2022 through 2027.

Proposed Removal of the Left Without Being Seen (LWBS) Measure

CMS proposes to remove the LWBS measure — a process measure that assesses the percent of patients who leave the emergency department (ED) without being evaluated by a physician, advanced practice nurse, or PA — beginning with CY 2024. CMS proposes to remove the measure under Removal Factor 2 (performance or improvement on the measure does not result in better patient outcomes). CMS does not believe the LWBS measure provides enough granularity for actionable data toward quality improvement and lacks sufficient evidence that the measure promotes quality of care and improved patient outcomes. CMS notes that it believes the Median Time from ED Arrival to ED Departure for Discharged ED Patients measure in OQR Program provides data that are more meaningful for quality improvement efforts.

Proposed Modifications to Previously Adopted Measures

CMS proposes to modify three previously adopted measures beginning with the CY 2024 reporting period/CY 2026 payment determination.

COVID-19 Vaccination Coverage Among HCP

CMS proposes to modify the COVID-19 Vaccination Coverage Among HCP measure to replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition. This will account for additional doses and boosters that have been made available since the measure was initially adopted. This proposal is consistent with proposed policies across all Medicare quality reporting programs. The modified measure would be calculated as follows:

- Numerator: The number of HCP in the denominator population who are considered up to date with CDC-recommended COVID-19 vaccines
- Denominator: The number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination that are described by the CDC. HCP includes employees of the facility, licensed independent practitioners, and adult students/trainees and volunteers. There are no proposed changes to the denominator from that of the current measure.
- Data Submission and Reporting: Providers would collect the numerator and denominator for the modified measure for at least one self-selected week during each month of the reporting quarter and submit the data for each of the three months in the reporting quarter to the NHSN Healthcare Personnel Safety Component before the quarterly deadline. Each quarter, the CDC would calculate a single quarterly COVID-19 HCP vaccination coverage rate for each provider, by taking the average of the data from the

three weekly rates submitted by the provider for that quarter. CMS expects to begin publicly reporting measure data with the Fall 2024 Care Compare refresh.

Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery (Cataracts Visual Function) Measure
In the CY 2023 OPPS final rule, CMS modified reporting requirements for the Cataracts Visual Function measure as a voluntary measure in response to ongoing stakeholder concerns with the burden of reporting this measure, as well as ongoing staffing and supply shortages. Beginning with the CY 2024 voluntary reporting period, CMS proposes to further reduce burden and improve data collection standardization by limiting the allowable survey instruments that may be used for the measure. Specifically, CMS proposes to allow the following survey instruments:

- 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)

Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Colonoscopy Follow-Up Interval) Measure
CMS proposes to modify the measure denominator of the Colonoscopy Follow-Up Interval measure to align with current clinical guidelines, beginning with CY 2024. Currently, the measure assesses the "percentage of patients aged 50 years to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report."

In May 2021, the United States Preventive Services Task Force (USPSTF) issued a revised Final Recommendation Statement on Colorectal Cancer (CRC) Screening, recommending that adults who do not have signs or symptoms of CRC and who are at average risk for CRC begin screening at age 45 instead of the previous recommendation of age 50. As such, CMS proposes to revise the measure denominator to "all patients aged 45 to 75 years."

Proposed Adoption of New Measures for the Hospital OQR Program Measure Set

CMS proposes to readopt one previously removed measure, and the adoption of two new measures.

Proposed Re-adoption with Modification of the Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (HOPD Procedure Volume) Measure
In the CY 2018 OPPS proposed rule, CMS removed the HOPD Procedure Volume Measure, citing a lack of evidence to support its link to a facility's overall performance or quality improvement with respect to surgical procedures. However, CMS now believes the increasing shift of more surgical procedures being performed in outpatient settings has made tracking volume of these procedures more important for informing patients. It cites more recent scientific literature concludes that volume metrics serve as an indicator of which facilities are experienced with certain outpatient procedures.

CMS proposes to readopt this measure with modification beginning with voluntary reporting in the CY 2025 reporting year and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.

The proposed measure collects data on the aggregate volume of selected surgical procedures, which are included in one of the following eight categories: cardiovascular, eye, gastrointestinal, genitourinary, musculoskeletal, nervous system, respiratory, and skin. CMS proposes to readopt the measure with the modification that instead of collecting and publicly displaying data on the eight categories broadly, it would collect and display more granular data for each category in the top five most frequently performed procedures in HOPDs. The top five for each category would be updated annually.

Data on the top five procedures in each category would be submitted through the Hospital Quality Reporting system and publicly displayed on Care Compare. Data would be submitted to CMS from Jan. 1 through May 15 in the year prior to the payment determination year. For 2028 payment determination, the data submission would be Jan. 1, 2027, through May 15, 2027 (covering the performance period of Jan. 1 to Dec. 31, 2026).

Risk-Standardized Patient-Reported Outcome-Based Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty in the HOPD Setting (THA/TKA PRO–PM)
The THA/TKA PRO-PM was adopted in the FFY 2023 IPPS final rule into the Hospital Inpatient Quality Reporting (IQR) Program. CMS proposes to adopt the measure into the OQR Program, using the same measure specifications as used in the IQR Program, but with modifications to include HOPD procedures. CMS proposes to adopt the measure with two initial voluntary reporting periods in 2025 and 2026, with mandatory reporting beginning with the 2027 Reporting Period/2030 payment determination.

The measure uses standardized, validated survey instruments completed within three months pre- and at about one-year post-operatively to assess patient-perceived pain and function. Risk adjustment includes numerous variables. Additional measure specifications are below:

- Numerator: Risk-standardized proportion of patients meeting pre-defined thresholds for substantial clinical improvement measured (90 to 0 days before surgery) from the preoperative assessment to the post-operative assessment (300-425 days after surgery)
- Denominator: Medicare beneficiaries aged 65 or older (enrolled in Medicare FFS parts A and B for the 12 months prior to the date of the procedure and during the procedure) undergoing elective primary outpatient THA or TKA procedures performed in HOPDs
- Exclusions: Patients with hip/knee fractures who have staged procedures or procedures that were started but not completed
- Calculation: All patient-level results for an HOPD facility are aggregated to produce a case-mix adjusted risk-standardized improvement rate. Patient Reported Outcome (PRO) tool response rates utilize completed matched pre- and post-operative assessments.
- Data Sources: PRO data directly reported by the patient, Medicare claims data, Medicare enrollment and beneficiary data, and Census Bureau survey data

Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults Measure (Excessive Radiation eCQM)
The Excessive Radiation eCQM provides a standardized method for monitoring the performance of diagnostic CT. The measure is not risk-adjusted and is expressed as a percentage of eligible CT scans that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam. This

measure was recently finalized as a measure available for hospital self-selection under the hospital IQR Program and the promoting interoperability program. CMS proposes to include this measure in the OQR program beginning with voluntary reporting in the 2025 reporting period and mandatory reporting beginning with the 2026 reporting period/2028 payment determination.

- Numerator: The number of diagnostic CT scans that have a size-adjusted radiation dose greater than the threshold defined for the specific CT category and diagnostic CT scans with a noise value greater than a threshold specific to the CT category
- Denominator: The number of all diagnostic CT scans performed on patients 18 years and older during the one-year measurement period that have an assigned CT category, a size-adjusted radiation dose value, and a global noise value
- Exclusions: CT scans that cannot be categorized by the area of the body being imaged or reason for imaging and CT scans missing information on the patient's age, Calculated CT Size-Adjusted Dose, or Calculated CT Global Noise
- Data Submission and Reporting: The measure uses hospitals' electronic health records data and radiology electronic clinical data systems, including the Radiology Information System and the Picture Archiving and Communication System. Since eCQMs cannot access and process data elements in the Digital Imaging and Communications in Medicine (DICOM) standard format, and medical imaging information is stored according to that format, the measure developer created translation software (Alara Imaging Software for CMS Measure Compliance), which would be made available to all reporting entities for free. The software links primary data elements, assesses CT scans for eligibility for inclusion in the measure, and generates three data elements to calculate the eCQM: CT Dose and Image Quality Category, Calculated CT Size-Adjusted Dose, and Calculated CT Global Noise.

Public Display of Median Time for Discharged ED Patients-Transfer Patients and Median Time for Discharged ED Patients-Overall Rate measures

The Median Time for Discharged ED Patients is a chart-abstracted measure that evaluates the time between the arrival to and departure from the ED, also known as ED throughput time. It is calculated in stratified subgroups for certain patients, but the stratified data for the "Transfer Patients" and "Overall Rate" subgroups of the measure are not currently publicly displayed on Care Compare. CMS proposes to begin publicly reporting this data on Care Compare beginning in 2024.

Request for Comment on Measurement Topics for Future Consideration

CMS seeks public comment on potential measurement topics for the OQR program. Specifically, CMS seeks comments to address quality measurement gaps in the HOPD setting, including the ED, changes in outpatient care (such as shifts in volume, technology, case complexity), concerns around workforce and patient safety, behavioral health and suicide prevention, telehealth, transitioning to digital quality measurement, and interest in patient-reported outcomes.

Rural Emergency Hospital (REH) Quality Reporting Program

The CAA of 2021 established REHs as a new provider type — beginning Jan. 1, 2023 — that provides ED services, observation care, and potentially other medical and health services on an outpatient basis. REHs must not provide acute care inpatient services, with the exception of skilled-nursing facility services in a distinct unit. Notably, the state of California does not currently license the REH provider type.

The CAA of 2021 also required the establishment of the REH quality reporting program. In the proposed rule, CMS proposes to adopt and codify policies related to measure retention, removal, and modification; public reporting; the form, manner, and timing of data submission; a review and corrections period for submitted data; and an Extraordinary Circumstances Exception (ECE) process.

CMS also proposes to adopt four initial measures for the REH quality reporting program. Each of the four measures is currently included in the hospital OQR program:

- Abdomen Computed Tomography (CT) – Use of Contrast Material
- Median Time from ED Arrival to ED Departure for Discharged ED Patients
- Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
- Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery

CHA refers readers to the proposed rule for more detail on the REH quality reporting program requirements.

Appendix I – Request for Information on Payment for Establishing and Maintaining Access to Essential Medicines

1) How effective would this potential payment policy be at improving the resiliency of the supply chain for essential medicines and the care delivery system?
    a. How could it be improved, either initially or through future rulemaking?
    b. Are there suggested alternative pathways for establishing similar separate payments?
2) The potential payment policy specified under section XXII.C of this proposed rule would account for any increased resource costs for a hospital to establish and maintain access to a buffer stock of domestically manufactured essential medicines compared to non-domestically manufactured ones. Even though the costs of essential medicines themselves is not considered a resource cost of establishing and maintaining access to a buffer stock, it is possible that there are additional resource costs, perhaps contractual, to establishing and maintaining access to a buffer stock of more expensive domestically manufactured essential medicines compared to non-domestically manufactured ones.
    a. What type of additional hospital resource costs are involved in establishing and maintaining access to domestically manufactured essential medicines compared to non-domestically manufactured ones? Are there alternative approaches that might better recognize the increased resource costs for a hospital to establish and maintain access to a buffer stock of domestically manufactured essential medicines?
    b. How might any suggested alternatives be better at improving the resiliency of the supply chain for essential medicines and the care delivery system? What standard should be used to define domestic manufacturing for suggested alternatives?
    c. Specifically, would the international trade rule of "substantial transformation" be appropriate to define domestic manufacturing, if that product was substantially transformed in the U.S.?
    d. Would hospitals have sufficient access to that information when making procurement decisions or doing reporting to CMS?
3) Are the 86 essential medicines prioritized in the report *Essential Medicines Supply Chain and Manufacturing Resilience Assessment* the appropriate initial list of essential medicines for this potential payment policy?
    a. How often should HHS consider updating the respective list used for establishing these potential additional payments?
    b. For example, HHS expects it may update the essential medicine list every two years. Should that be the frequency for purposes of administering these additional payments?
    c. Also, what additional criteria should be considered when determining whether the list should be updated?
    d. Should HHS consider expanding the list of essential medicines used in establishing these potential additional payments to include essential medicines used in the treatment of cancer?
    e. Is a 3-month supply the appropriate amount of supply for the buffer stock or should an alternative duration be used?

f. We recognize that a 3-month supply may not be feasible in all circumstances, given various factors, including, but not limited to, the shelf life of certain essential medicines.
    i. What additional considerations, if any, are needed?
g. In general, how much of a buffer stock of these essential medicines are hospitals currently maintaining across different hospital types and regions (whether directly, or contractually through distributors or other partners)?
    i. Are there unique circumstances for safety net hospitals that should be taken into consideration in any potential payment policy?
h. What type of additional hospital resource costs are involved in establishing and maintaining access to a buffer stock of essential medicines?
    i. To what degree, and under what circumstances, might hospitals use contractual arrangements?
    ii. What type of contractual arrangements might be used?
i. What flexibilities should exist for implementing buffer stock practices?
j. What immediate impacts on the supply of essential medicines could be expected upon implementation of this potential policy? What steps, if any, would need to be taken to mitigate risks of possible demand-driven shortages as a result of implementation of such a policy?
k. While the availability of essential medicines is critical at all times, it is especially the case for emergencies. Should there be a separate payment adjustment to more acutely address supply issues that emerge specific to the case of preparedness as a pandemic or other public health emergency emerges?
l. How should such a policy be considered for essential medicines that are currently in shortage, and thus potentially not appropriate for arranging to have buffer stock?
    i. What steps, if any, would need to be taken if an eligible essential medicine enters shortage while such a policy is in place?
m. Should critical medical devices be considered in future rulemaking for inclusion in a potential payment policy?
    i. Which types of medical devices do hospitals currently maintain in a buffer stock?
    ii. Do single use devices (including consumables) or reusable devices pose a greater risk of supply chain impact leading to shortages
    iii. Are hospitals more likely to have a buffer stock of devices that are single use (including consumables) or reusables?
    iv. What levels of buffer stock do hospitals currently keep on hand for devices they consider critical?
    v. Is the quantity of buffer stock dependent on type of medical device (single use vs. reusable)?
    vi. Generally, how many days of buffer stock is typically carried by device type?
    vii. What other factors are considered when determining which types of medical devices to maintain in a buffer stock?
    viii. What are the prevailing buffer stock strategies employed across deice types (e.g., just in time) consignment, single warehousing, warehouse to warehouse)?

Appendix II – Request for Information on Consumer-Friendly Displays and Alignment with Transparency in Coverage and No Surprises Act

1) How, if at all, and consistent with its underlying legal authority, could the HPT consumer-friendly requirements at § 180.60 be revised to align with other price transparency initiatives?
2) How aware are consumers about healthcare pricing information available from hospitals? We solicit recommendations on raising consumer awareness.
3) What elements of health pricing information do you think consumers find most valuable in advance of receiving care?
    a. How do consumers currently access this pricing information?
    b. What are consumers' preferences for accessing this price information?
4) Given the new requirements and authorities through TIC final rules and the NSA, respectively, is there still benefit to requiring hospitals to display their standard charges in a "consumer-friendly" manner under the HPT regulations?
5) Within the contours of the statutory authority conferred by section 2718(e) of the PHS Act, should information in the hospital consumer-friendly display (including the information displayed in online price estimator tools) be revised to enhance alignment with price information provided under the TIC final rules and NSA regulations?
    a. If so, which data should be revised and how?
6) How effective are hospital price estimator tools in providing consumers with actionable and personalized information? What is the minimum amount of personalized information that a consumer must provide for a price estimator tool to produce a personalized out-of-pocket estimate?
7) How are third parties using MRF data to develop consumer-friendly pricing tools?
    a. What additional information is added by third parties to make standard charges consumer-friendly?
8) Should we consider additional consumer-friendly requirements for future rulemaking, and to the extent our authorities permit?
    a. For example, what types of pricing information might give consumers the ability to compare the cost of healthcare services across healthcare providers?
    b. Is there an industry standard set of healthcare services or service packages that healthcare providers could use as a benchmark when establishing prices for consumers?

Appendix III – Hospital Outpatient Quality Reporting Program Measures Table

Measure		Payment Determination				
CBE #		2023	2024	2025	2026	2027
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED arrival	X	X	Removed		
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention	X	X	Removed		
0514	OP-8: MRI Lumbar Spine for Low Back Pain	X	X	X	X	X
	OP-10: Abdomen CT – Use of Contrast Material	X	X	X	X	X
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	X	X	X	X	X
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients	X	X	X	X	X
0499	OP-22: ED - Left Without Being Seen	X	X	X	Proposed Removal	
0661	OP-23: ED - Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival	X	X	X	X	X
0658	OP-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients*	X	X	X	X	X
1536	OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery*		Voluntary	Voluntary	Voluntary	Voluntary
2539	OP-32: Facility Seven-Day Risk Standardized Hospital Visit Rate After Outpatient Colonoscopy	X	X	X	X	X
	OP-35: Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	X	X	X	X	X
2687	OP-36: Hospital Visits After Hospital Outpatient Surgery	X	X	X	X	X
	OP-37a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures				Voluntary	X
	OP-38: COVID-19 Vaccination Coverage Among Health Care Personnel (HCP)*			X	X	X
	OP-39: Breast Cancer Screening Recall Rates		X	X	X	X
	OP-40: ST-Segment Elevation Myocardial Infarction (STEMI) eCQM				Voluntary	X

	HOPD Procedure Volume**					Proposed Voluntary
	THA/TKA PRO-PM**					Proposed Voluntary
3663e	Excessive Radiation eCQM**					Proposed Voluntary

*Modifications proposed
**Newly proposed measure