SUMMARY OF FINAL RULE – NOVEMBER 2023

CY 2024 Outpatient Prospective Payment System

Overview

In the Nov. 2 *Federal Register,* the Centers for Medicare & Medicaid Services (CMS) published a final rule providing updates and policy changes to the Medicare outpatient prospective payment system (OPPS) for calendar year (CY) 2024. The policy and payment provisions are generally effective for CY 2024 services, beginning Jan. 1, 2024, unless otherwise noted.

The following is a comprehensive summary of the final 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, and additional price transparency requirements.

The final 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.

Contents

Summary of Key Provisions 4
CY 2024 OPPS Payment Update 4
Updates Affecting OPPS Payments 6
Recalibration of APC Relative Payment Weights 6
Universal Low-Volume APCs Payment Policy 6
Changes to Packaged Items and Services 6
Wage Index Changes 6
Sole Community Hospital (SCH) Adjustment 6
Cancer Hospital Adjustment 6
Outpatient Outlier Payments 6
New Technology APCs 6
Pass-Through Payments for Devices 6
New Device Pass-Through Applications 7
Device-Intensive Procedures 7
Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals 8
OPPS Payment Methodology for 340B-Purchased Drugs 9
Hospital Outpatient Visits 10
Inpatient-Only (IPO) List 10
Request for Information on Establishing and Maintaining Access to Essential Medicines 11
Updates to Hospital Requirements to Make Public Standard Charges 11
Changes to Requirements 12
Changes to Improve and Enhance Enforcement 14
Partial Hospitalization Program and Intensive Outpatient Services 14
Revisions to PHP Physician Certification Requirements 15
IOP Scope of Benefits 15
IOP Certification and Plan of Care Requirements 16
Coding and Billing for PHP and IOP Services under the OPPS 16
Payment Methodology for PHP and IOP 17
IOP Services Provided in RHC and FQHC Settings 18
Payment Rates in Non-Excepted Off-Campus Provider-Based Departments (PBDs) 19
Mental Health Services Furnished to Patients in their Homes 19
Outpatient Therapy, Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT) 20
Supervision of Cardiac and Pulmonary Rehabilitation Services 20

Payment of Intensive Cardiac Rehabilitation in a Non-Excepted Off-Campus PBD 20
OPPS Payment for Dental Services 20
Hospital OQR Program 21
Left Without Being Seen (LWBS) Measure 22
Modifications to Previously Adopted Measures 22
Proposed Adoption of New Measures for the Hospital OQR Program Measure Set 23
Public Display of Median Time for Discharged ED Patients-Transfer Patients and Median Time for Discharged ED Patients-Overall Rate measures 24
Rural Emergency Hospital (REH) Quality Reporting Program 25
Appendix I – Price Transparency Implementation Timelines 26
Appendix II – Hospital Outpatient Quality Reporting Program Measures Table 28

Summary of Key Provisions

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

- Increase the market basket by a net 3.1%
- 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 final rule and other resources related to the OPPS are available on the CMS website. Comments are due to CMS by Jan. 1, and can be submitted electronically using the website's search feature for "CMS-1786–FC."

The increase in OPPS spending due only to changes in the 2024 OPPS rule is estimated to be approximately $2. 2 billion. Considering estimated changes in enrollment, utilization, and case mix for 2024, CMS estimates that OPPS expenditures, including beneficiary cost-sharing, will be approximately $88.9 billion, which is approximately $6 billion higher than estimated OPPS expenditures in 2023.

CY 2024 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 CY2024. CMS finalizes the use of CY 2022 claims data and CY 2021 Healthcare Cost Report Information System data from the December 2022 extract.

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

	Final CY 2023	Final CY 2024	Percent Change
OPPS Conversion Factor	$85.585	$87.382 (proposed at $87.488)	+2.10% (proposed at +2.22%)

Final CY 2024 Update Factor Component	Value
Market Basket Update	+3.3% (proposed at +3.0%)
Affordable Care Act (ACA)–Mandated Productivity	–0.2 percentage points (PPT) (as proposed)
Wage Index Budget Neutrality (BN) Adjustment	-0.88% (proposed at -0.26%)
Wage Index 5% Stop Loss BN	-0.03% (proposed at -0.25%)
Pass–Through Spending/Outlier BN Adjustment	-0.11% (proposed at -0.10%)
Cancer Hospital BN Adjustment	+0.05% (as proposed)
Overall Final Rate Update	**+2.10%** (proposed at +2.22%)

CMS estimates the final update to the conversion factor net of the total factor productivity (TFP) will increase payments 3.1% in 2024 (market basket of 3.3%, less 0.2% for TFP).

CMS notes the following estimated impacts in Table 168 of the final rule:

Facility Type	Estimated 2024 Impact (Final)
All Hospitals	3.3%
Urban – All	3.2%
Urban – Pacific Region	6.0%
Rural – All	4.2%
Rural – Pacific Region	7.3%

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

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

California

Impact Analysis	Dollar Impact	% Change
Estimated CY 2023 OPPS Payments	*$6,670,573,400*	
Market Basket Update	$175,528,600	2.63%
ACA-Mandated Productivity Adjustment	($10,638,600)	-0.16%
Budget Neutrality Adjustments	($53,210,500)	-0.80%
Wage Index (Removal of Previous Bottom Quartile and Stop Loss (including rural floor))	($443,900)	-0.01%
Wage Index (Removal of Previous Rural Floor BN)	$30,506,500	0.46%
Wage Index (Removal of Previous Rural Floor Wage Index)	($39,943,800)	-0.60%
Wage Index (Change due to WI and LS prior to rural floor)	$6,224,700	0.09%
Wage Index (Current Rural Floor Wage Index Added)	$405,378,200	6.08%
Wage Index (Current Rural Floor Budget Neutrality Added)	($90,486,700)	-1.36%
Increasing Bottom Quartile Wage Index Values	$0	0.00%
Wage Index 5% Stop Loss	$420,900	0.01%
Change in Rural Add-On	$0	0.00%
APC Factor/Updates	$47,587,100	0.71%
Estimated CY 2024 OPPS Payments	*$7,141,495,900*	
Total Estimated Change From CY 2023 to CY 2024	**$470,922,500**	**7.06%**

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: $142,829,900

Source: CHA DataSuite Analysis, November 2023

Updates Affecting OPPS Payments

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 final payment rates for these New Technology APCs are included in Addendum A to this rule.

Pass-Through Payments for Devices

There are currently 15 device categories eligible for pass-through payment. Table 84 (reproduced below) lists the devices and their pass-through expiration.

Table 84: 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	12/31/2023
C1982*	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2023
C1839*	Iris prosthesis	1/1/2020	12/31/2023
C1734*	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2023
C2596*	Probe, image-guided, robotic, waterjet ablation	1/1/2020	12/31/2023
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	1/1/2023	12/31/2025

Table 84: 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**
	components, with rechargeable battery and charging system		
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. Of these, the following four have been approved for pass-through payment.

- CavaClear Inferior Vena Cava (IVC) Filter Removal Laser Sheath
- CERAMENT® G
- Ambu® aScopeTM 5 Broncho HD
- 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 did not adopt any changes to the device-intensive policy. The full list of 2024 device-intensive procedures is provided in Addendum P.

Device Edit Policy

CMS will continue requiring 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 reassigned 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 finalizes 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 are 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 did not adopt 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 finalizes a packaging threshold of $135 (proposed at $140). Drugs, biologicals, and radiopharmaceuticals that are above the $135 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 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.

CMS 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. Therefore, beginning with CY 2024, biosimilars would be exempt from the OPPS threshold packaging policy when their reference biologicals are separately paid (CMS will paid separately for these biosimilars even if their per-day cost is below the packaging threshold). However, CMS is not currently adopting the proposal that if a reference product's per-day cost falls below the threshold, 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 finalizes that pass–through status expires on Dec. 31, 2023, for 43 drugs and biologicals listed in Table 89; by Dec. 31, 2024, for 25 drugs and biologicals listed in Table 90. It will continue/establish pass-through status in CY 2024 for 59 drugs and biologicals shown in Table 91.

OPPS Payment Methodology for 340B-Purchased Drugs

CMS finalizes 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 November 2023, CMS published a "remedy final rule" addressing the reduced payment amounts to 340B hospitals under the reimbursement rates in the CYs 2018 through 2022 OPPS final rules. The remedy rule does not make changes to CY 2024 OPPS drug payment policies nor the 2024 conversion factor but does implement a -.5% reduction to the OPPS conversion factor beginning in CY 2026. For additional information, please refer to CHA's executive and detailed summaries of the final 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 only requires a single modifier "TB" for 340B-covered entities, effective Jan. 1, 2025. The "JG" will 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 will 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 packaged skin substitutes and their group assignments may be found in Table 95.

Hospital Outpatient Visits

For CY 2024, CMS finalizes that excepted off-campus PBDs of rural SCHs be exempt from the clinic visit payment policy. This is 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 must continue to bill HCPCS code G0463 with modifier "PO," but CMS will pay these hospitals the full OPPS payment rate.

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

Additionally, CMS finalized its proposal to apply the community mental health center (CMHC) per-diem rates for hospital PHP and IOP services provided at an off-campus PBD, instead of the MPFS rate for that service.

Lastly, CMS observed that the reduction to non-excepted PBDs for intensive cardiac rehabilitation (ICR) services resulted in an unintended reimbursement disparity between excepted and non-excepted sites of service, which created a barrier to beneficiary access. Therefore, beginning Jan. 1, 2024, CMS will 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 removing any procedures from the IPO list.

Further, in the final rule CMS adds the following services to the IPO list:

- CPT 0790T: Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed
- CPT 22836: Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to seven vertebral segments
- CPT 22837: Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; eight or more vertebral segments
- CPT 22838: Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed
- CPT 61889: 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 76984: Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic
- CPT 76987: Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation, and report
- CPT 76988: Intraoperative epicardial cardiac ultrasound (i.e., echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only
- CPT 76989: Intraoperative epicardial cardiac ultrasound (i.e., echocardiography) for congenital heart disease, diagnostic; interpretation and report only

- CPT 0646T: Transcatheter tricuspid valve implantation /replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed.

The full list of procedures on the IPO list is available in Addendum E of the final rule.

Request for Information on Establishing and Maintaining Access to Essential Medicines

In the proposed OPPS rule, CMS requested comments on a variety of considerations that would be associated with a potential add-on payment for the cost associated with establishing and maintaining access to a buffer stock of essential medicines. Among the questions CMS posed are:

- Whether the policy it is contemplating could be improved upon
- Alternatives to the proposed policy
- What are other types of costs hospitals would have to maintain this buffer stock
- Should there be standards to define domestic production like there are with the subsidies for N95 masks
- Are there are other medications besides the 86 essential medicines listed in the Administration for Strategic Preparedness and Response report that should be added
- What is an appropriate frequency for updating the list of essential medicines
- Whether a three-month supply is sufficient or should the buffer stock have a larger supply

All commenters who responded acknowledged the importance of addressing domestic drug shortages and medical supply chain disruptions. However, there was a lack of consensus among commenters about a potential Medicare payment policy. CMS is not finalizing any changes at this time but intends to propose future policy addressing aspects of hospital practices with respect to pharmaceutical supply, including future payment rules and through Conditions of Participation.

Some commenters were supportive of the potential separate payment, noting the importance of implementing a policy in a way that mitigates potential for demand-driven shortages. The majority of commenters did not support making a reasonable cost payment to maintain a buffer stock of essential medicines because they are concerned that design changes would be necessary to avoid exacerbating existing drug shortages or causing demand-driven shortages.

CMS agrees with commenters that a multifaceted approach is likely necessary. As part of its initial efforts, CMS intends to propose new Conditions of Participation in forthcoming notice and comment rulemaking addressing hospital processes for pharmaceutical supply. CMS will consider these comments in developing future payment policy.

Updates to Hospital Requirements to Make Public Standard Charges

Section 2718(e) of the Public Health Service Act requires each hospital operating within the U.S. 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 finalizes the following:

- "CMS template" means a CSV format or JSON schema that CMS makes available for purposes of compliance with the price transparency requirements
- "Encode" is converting hospital standard charge information into a machine-readable format that meets CMS requirements
- "Estimated allowed amount" is the average dollar amount that the hospital has historically received from a third-party payer for an item or service
- "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 is finalizing a new general requirement that, beginning Jan. 1, 2024, each hospital must make a good faith effort to ensure that the standard charge information encoded in the MRF is true, accurate, and complete as of the date indicated in the MRF. In addition, CMS is finalizing its policy as proposed — with a modification that — beginning July 1, 2024, the hospital must *affirm in its MRF* that, *to the best of its knowledge and belief, the hospital has included all applicable standard charge information,* and the information is true, accurate, and complete. (Italics added to emphasize the difference between the Jan. 1 and July 1, 2024, requirements.

Improving Standardization of MRF Formats and Data Elements: As part of its efforts to improve standardization, CMS is finalizing the following requirements 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:
    - Hospitals must encode the name(s) and address(es) of each hospital inpatient location and each standalone emergency department in the MRF. Hospitals are not required to encode all off-campus locations. CMS clarifies that it is sufficient for a hospital to post a single file of standard charges for a single campus location, if the file includes charges for all items and services offered at the single campus location. In cases where such off-campus and affiliated sites operate under the same license (or approval) as a main location but have different standard charges or offer different items and services, these locations would separately make public the standard charges for such locations. 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.
    - Display the payer-specific negotiated charges 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.

  - Indicate the contracting method they used to establish the payer-specific negotiated charge. CMS clarifies the name of this data element as the "standard charge methodology."
  - 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 "estimated allowed amount," where the payer-specific negotiated charge cannot be expressed as a dollar figure such as when the payment is based on an algorithm. The final rule modifies the definition to refer to the average amount "historically received" (rather than "expects to be paid"). CMS also indicates that a hospital would only be required to calculate an estimated allowed amount, in dollars, when the hospital has established a payer-specific negotiated charge that can only be expressed as a percentage or an algorithm.
- *Data Elements Related to Hospital Items and Services*: Requires hospitals to encode:
  - A general description of the item or service
  - Whether the item or service is provided in connection with an inpatient admission or an outpatient department visit
  - For drugs, the drug unit and type of measurement, beginning Jan. 1, 2025
- *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. The final rule clarifies that a hospital would not be required to encode all combinations of codes, including modifiers, for each standard charge established. Instead, the hospital would be required to separately encode the modifiers and indicate what effect the modifier would have on the standard charge. To reduce burden, the hospital would encode the standard charge associated with each five-digit code, as they have been established, and then separately encode each modifier that may change the standard charge by including a description of the modifier and the way it modifies the standard charge. The requirement to encode modifiers that affect the standard charge is effective Jan. 1, 2025.
- *Specify Formatting Requirements*:
  - Hospitals must 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. CMS affirms that it will not require encoding of an indicator in place of blanks citing the requirement to include an affirmation of the accuracy and completeness of the data as an indicator that blanks are intentional and not missing data.
  - Beginning July 1, 2024, the hospital's MRF must conform to a CMS template layout, data specifications, and data dictionary for purposes of making public the standard charge information. CMS reiterates that it is finalizing a phased implementation timeline with respect to the changes being adopted in the final rule. The effective date of all the changes to the hospital price transparency regulations will be Jan, 1, 2024. However, the regulation text will specify later

dates by which hospitals must comply with some requirements. The dates by which hospitals must comply with each of the new requirements are described in Tables 151A and 151B of the final rule. These tables are included in Appendix 1.

Improving Accessibility of Hospital MRFs: CMS is finalizing as proposed the requirement that the hospital ensure the public website includes a .txt file in the root folder that includes a standardized set of fields:

- The hospital location name that corresponds to the MRF
- The source page URL that hosts the MRF
- A direct link to the MRF (the MRF URL)
- Hospital point of contact information

CMS is also finalizing the requirement that the hospital ensures it has a footer on its public website, including but not limited to the homepage, that is labeled "Price Transparency" (instead of "Hospital Price Transparency") and links directly to the publicly available web page that hosts the link to the MRF.

Changes to Improve and Enhance Enforcement

In the final rule, CMS distinguishes "monitoring" hospital compliance — which may include evaluating complaints, reviewing an analysis of noncompliance 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 the following provisions 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 — upon request — 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. CMS clarifies that the formal certification is part of the method to monitor and assess hospital compliance. It is not required that the hospital post it publicly.
- Requiring submissions — upon CMS request — of additional documentation that may be necessary to assess hospital compliance.

CMS further finalized its proposals to:

- Require hospitals to acknowledge receipt of a warning notice
- Notify 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
- Indicate 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.

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 CMHC. PHP providers are paid on a per-diem basis, with payment rates calculated using CMHC- or hospital-specific data. CMS finalizes 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 for IOP 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). In the final rule, CMS proposes establishes payment and program requirements for IOP services beginning with CY 2024.

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 amends the regulations to require 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 codifies conditions and exclusions applicable to IOP services. They 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
(iii) furnished under a physician certification and plan of care

CMS defines 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 lists items and services that would be covered IOP services, which mirror the scope of services for PHP services. Specifically, IOP services can 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," 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 specifies 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 establishes 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
- Can tolerate the intensity of the IOP program

CMS adds 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 codifies 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 finalizes its proposal 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 will 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 should occur no less than every 60 days. 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 finalizes its proposal to require hospitals and CMHCs to report condition code 92 on claims for IOP services. Hospitals will

continue to report condition code 41 for PHP claims, and CMS finalizes its proposal to require CMHCs also report condition code 41 for PHP claims beginning on Jan. 1, 2024. CHA refers readers to Table 98 of the final rule, which lists the codes that apply for the full range of services that may be provided by PHPs and IOPs.

Payment Methodology for PHP and IOP

Beginning in CY 2024, CMS establishes 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 finalizes its proposal to calculate the hospital-based PHP payment rates for three services per day and four services per day based on cost per day using the broader OPPS data set. This represents a change from the current methodology of using only PHP data, and CMS believes it will result in more precise calculations. CMS will continue to calculate CMHC payment rates based solely on CMHC claims to recognize differences in cost structures for different PHP providers.

CMS had proposed using the three services per day hospital-based PHP APC per-diem payment amount for APC 5863 as the daily mental health cap, which serves as the upper limit on payment per day for individual OPPS mental health services. Commenters overwhelming recommended using APC 5864, which would be the most resource-intensive mental health service APC and thus more appropriate to use as the cap. CMS agrees with commenters and finalizes the use of APC 5864 to establish the payment rate for APC 8010 in 2024.

CMS establishes consistent coding and payment between the PHP and IOP benefits. Therefore, it will consider all OPPS data for PHP days and non-PHP days that include three services per day and four services per day and 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 final CY 2024 PHP and IOP payment rates:

	Final Payment Rate 2023	Final Payment Rate 2024	Percent Change
APC 5853: Partial Hospitalization (3+ services) for CMHCs	$142.70	$87.66	-38.57%
APC 5854: Partial Hospitalization (4+ services) for CMHCs	-	$157.58	-
APC 5851: Intensive Outpatient (3+ services) for CMHCs	-	$87.66	-
APC 5852: Intensive Outpatient (4+ services) for CMHCs	-	$157.58	-
APC 5863: Partial Hospitalization (3+ services) for Hospital-based PHPs	$268.22	$259.40	-3.29%
APC 5864: Partial Hospitalization (4+ services) for Hospital–based PHPs	-	$358.21	-
APC 5861: Intensive Outpatient (3+ services) for Hospital–based IOPs	-	$259.40	-
APC 5862: Intensive Outpatient (4+ services) for Hospital–based IOPs	-	$358.21	-

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

CMS will 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. CMS will also expand the calculation of the CMHC outlier percentage to include PHP and IOP.

IOP Services Provided in RHC and FQHC Settings

CMS generally establishes 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 by 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 establishes 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 the FQHC's actual charges or the rate determined for APC 5861
- For grandfathered tribal FQHCs, payment will be based on the lesser of the FQHC's actual charges or the outpatient per visit rate

CMS finalizes its proposal to require RHCs and FQHCs to report condition code 92 to identify IOP claims for the list of proposed HCPCS codes included in Table 98. 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 99 of the final 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 makes 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 applies the same policy for IOP services furnished by FQHCs.

CMS modifies 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; there are exceptions for patients with a medical visit or physical exam visit and a mental health visit on the same day. However, CMS clarifies that 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 non-excepted off-campus PBDs are set at the rate equal to the CMHC payment rate for three or more PHP services per day. CMS finalizes its proposal 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; CMS will 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 finalizes its proposal to create a new, untimed, HCPCS C-code describing group therapy. CMS will assign this new C-code to APC 5821, which pays $28.08. This APC assignment was originally proposed 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. However, in response to commenters who demonstrated that hospitals continue to incur costs even when patients are not in the hospital, CMS will instead use the higher non-facility PFS payment rate.

CMS also modifies 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 delays its previously finalized policies that require a patient to receive an in-person visit within six months prior to the first time a mental health service is provided remotely. It also delays the requirement that there 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 , and Medical Nutrition Therapy
CMS finalizes its proposal 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 final rule, CMS finalized its proposal 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 final 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 finalizes its proposal 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 of 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 extends this policy through the end of CY 2024 and also extends the authority for virtual supervision of these services 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 finalizes its proposal 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 will 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 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 will assign 243 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 makes 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 making 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 111 of the final rule for the list of dental codes assigned 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.

CMS finalizes several changes to the OQR measures set, including the modification of three existing measures, the adoption of two new measures, including one electronic clinical quality measure (eCQM), with modifications from the proposal. CMS did not finalize proposals to remove one measure and re-adopt a volume measure. CMS also proposes policies related to public reporting of data for one measure.

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.

Left Without Being Seen (LWBS) Measure

CMS did not finalize its proposal 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. After reviewing public comments and analyzing more recent measure data, CMS determined the measure continues to provide meaningful information and will not remove the measure from the OQR program at this time.

Modifications to Previously Adopted Measures

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

COVID-19 Vaccination Coverage Among HCP

CMS finalizes its proposal 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 is consistent with policies across all Medicare quality reporting programs. The modified measure will 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 will 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 will 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 finalized its proposal to further reduce the burden and improve data collection standardization by limiting the allowable survey instruments that may be used for the measure. Specifically, CMS will 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 finalizes its proposal 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 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 will 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 adopts two new measures, with modifications from the proposed rule. CMS will not finalize its proposal to re-adopt a volume measure.

Re-adoption with Modification of the Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (HOPD Procedure Volume) Measure
In response to comments from CHA and other stakeholders, CMS does not finalize its proposal to re-adopt a modified version of the HOPD Procedure Volume measure, which would have collected and publicly reported data on the aggregate volume of certain selected surgical procedures. While CMS continues to believe that volume can be an indicator of quality, it acknowledged commenter concerns that the data would be confusing to Medicare beneficiaries, and also expressed concern with the failure of the measure to include Medicare Advantage patients.

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 finalizes its proposal 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. In response to comments, CMS will extend voluntary reporting of the measure by one additional year, adopting the measure with three initial voluntary reporting periods in 2025, 2026, and 2027, with mandatory reporting beginning with the 2028 Reporting Period/2031 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. In response to comments, CMS finalizes its proposal to include this measure in the OQR Program but expands the voluntary reporting period to include the 2025 and 2026 reporting years. Mandatory reporting of the measure is finalized beginning with the 2027 reporting period/2029 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 aged 18 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 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 finalizes its proposal to begin publicly reporting this data on Care Compare beginning in 2024.

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 adopts and codifies 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 finalizes its proposal to adopt four initial measures for the REH Quality Reporting Program beginning with CY 2024. 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 final rule for more detail on the REH Quality Reporting Program requirements.

Appendix I – Price Transparency Implementation Timelines

Table 151A: Implementation Timeline for CMS Template Adoption and Encoding Data Elements		
Requirement	**Regulation cited**	**Implementation (Compliance) Date**
MRF INFORMATION		
MRF Date	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
CMS Template Version	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
HOSPITAL INFORMATION		
Hospital Name	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Location(s)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Address(es)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Licensure Information	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
STANDARD CHARGES		
Gross Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Discounted Cash	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Payer Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Plan Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Standard Charge Method	45 CFR 180.50(b)(2)(ii)(B)	July 1, 2024
Payer-Specific Negotiated Charge –Dollar Amount	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Percentage	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Algorithm	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Estimated Allowed Amount	45 CFR 180.50(b)(2)(ii)(C)	Jan. 1, 2025
De-identified Minimum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
De-identified Maximum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
ITEM & SERVICE INFORMATION		
General Description	45 CFR 180.50(b)(2)(iii)(A)	July 1, 2024
Setting	45 CFR 180.50(b)(2)(iii)(B)	July 1, 2024
Drug Unit of Measurement	45 CFR 180.50(b)(2)(iii)(C)	Jan. 1, 2025
Drug Type of Measurement	45 CFR 180.50 (b)(2)(iii)(C)	Jan. 1, 2025
CODING INFORMATION		
Billing/Accounting Code	45 CFR 180.50(b)(2)(iv)(A)	July 1, 2024
Code Type	45 CFR 180.50(b)(2)(iv)(B)	July 1, 2024
Modifiers	45 CFR 180.50(b)(2)(iv)(C)	Jan. 1, 2025

Table 151B: Implementation Timeline for Other New Hospital Price Transparency Requirements

Requirement	Regulation Cited	Implementation (Compliance) Date
Good faith effort	45 CFR 180.50(a)(3)(i)	Jan. 1, 2024
Affirmation in the MRF	45 CFR 180.50(a)(3)(ii)	July 1, 2024
Txt file	45 CFR 180.50(d)(6)(i)	Jan. 1, 2024
Footer link	45 CFR 180.50(d)(6)(ii)	Jan. 1, 2024

Appendix II – 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	X	X
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				X	X

	THA/TKA PRO-PM**					Voluntary
3663e	Excessive Radiation eCQM**					Voluntary

* Modified Measure
**Newly finalized measure