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Calendar Year 2023 Hospital Outpatient Prospective Payment System Proposed Rule

On July 15th, 2022 the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2023 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. This rule provides for a 60-day comment period ending on September 13th, 2022. The finalized changes are effective January 1st, 2023.

Conversion Factor Update

CMS proposes to increase the conversion factor by 2.7 percent bringing it up to $ 86.785 for CY 2023. This increase is based on the proposed hospital inpatient market basket percentage increase of 3.1 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a proposed productivity adjustment of 0.4 percentage point. CMS proposes further to adjust the conversion factor to ensure that any revisions made to the wage index and rural adjustment are made on a budget neutral basis. CMS proposes to calculate an overall budget neutrality factor of 1.0010 for wage index changes by comparing proposed total estimated payments from simulation model using the proposed FY 2023 IPPS wage indexes to those payments using the FY 2022 IPPS wage indexes, as adopted on a calendar year basis for the OPPS. CMS further proposes to calculate an additional budget neutrality factor of 0.9995 to account for the proposed policy to cap wage index reductions for hospitals at 5 percent on an annual basis. CMS proposes to maintain the current rural adjustment policy, and therefore proposes the budget neutrality factor for the rural adjustment to be 1.0000.

CMS proposes that hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program would be subject to a further reduction of 2.0 percentage points. Hospitals that fail to meet the requirements would result in a conversion factor for CY 2023 of $ 85.093.

CMS proposes to use CY 2021 claims data to set CY 2023 OPPS and ASC rates. In order to mitigate the impact of some of the temporary changes in hospitals cost report data from CY 2020 due to the COVID-19 public health emergency, CMS proposes to use cost report data from the June 2020 extract from Healthcare Cost Report Information System (HCRIS), which includes cost report data from prior to the PHE. This is the same cost report extract that was used to set OPPS rates for CY 2022.

Estimated Impact on Hospitals

CMS estimates that OPPS expenditures, including beneficiary cost-sharing will be approximately $86.2 billion, which is approximately $6.2 billion higher than estimated CY 2022 OPPS expenditures.

PROPOSED AMBULATORY PAYMENT CLASSIFICATION GROUP POLICIES

Imaging Ambulatory Payment Classifications

CMS does not propose any new changes to the APC structure for imaging codes. The seven payment categories remain. However, CMS has moved codes within these payment categories which would cause changed pricing for 2023. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two times rule.

Proposed CY 2023 Imaging APCs

APC	Group Title	SI	Relative Weight	CY 2022 Payment Rate	CY 2023 Proposed Payment Rate
5521	Level 1 Imaging without Contrast	S*	1.0158	$82.61	$88.16
5522	Level 2 Imaging without Contrast	S	1.2563	$111.19	$109.03
5523	Level 3 Imaging without Contrast	S	2.7452	$235.00	$238.24
5524	Level 4 Imaging without Contrast	S	5.9080	$493.48	$512.73
5571	Level 1 Imaging with Contrast	S	2.1157	$182.43	$183.61
5572	Level 2 Imaging with Contrast	S	4.3223	$376.09	$375.11
5573	Level 3 Imaging with Contrast	S	8.6598	$730.67	$751.54

*****Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment.

Proposed APC Exceptions to the 2 Times Rule

CMS proposes exceptions to the 2-times rule based on the following criteria: resource homogeneity; clinical homogeneity; hospital outpatient setting utilization; frequency of service (volume); and opportunity for up-coding and code fragments.

Table 8, found below, lists the 23 APCs that CMS proposes to exempt from the 2 times rule for 2023 based on claims data from January 1, 2021, through December 31, 2021, and processed on or before December 31, 2021.

Table 8. Proposed APC Exceptions to the 2 Times Rule for 2023

2023 APC	APC Title
5012	Clinic Visits and Related Services
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5301	Level 1 Upper GI Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5611	Level 1 Therapeutic Radiation Treatment Preparation
5612	Level 2 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5673	Level 3 Pathology
5691	Level 1 Drug Administration

5692	Level 2 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5734	Level 4 Minor Procedures
5741	Level 1 Electronic Analysis of Devices
5791	Pulmonary Treatment
5811	Manipulation Therapy
5821	Level 1 Health and Behavior Services
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Comprehensive APCs

For CY 2023, CMS proposes the creation of 1 new comprehensive APC (C-APC): Proposed C-APC 5372 (Level 2 Urology and Related Services). Table 1. in the proposed rule details the proposed C-APCs.

Changes to New-Technology APCs

Payment Rate for the MRgFUS Procedures

There are currently four CPT/HCPCS codes that describe magnetic resonance image-guided, high-intensity focused ultrasound (MRgFUS) procedures, three of which CMS proposes to continue to assign to standard APCs, and one that CMS proposes to continue to assign to a New Technology APC for CY 2023.

Proposed CY 2023 Status Indicator (SI), APC Assignment, And Payment Rate for the MRgFUS Procedures

CPT/ HCPCS Code	Long Descriptor	CY 2022 OPPS SI	CY 2022 OPPS APC	CY 2022 OPPS Payment Rate	Proposed CY 2023 OPPS SI	Proposed CY 2023 OPPS APC	Proposed CY 2023 OPPS Payment Rate
0071T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume less than 200 cc of tissue.	J1*	5414	$ 2,679.56	J1	5414	$ 2881.19
0072T	Focused ultrasound ablation of uterine leiomyomata,	J1	5414	$ 2,679.56	J1	5414	$2,881.19

	including mr guidance; total leiomyomata volume greater or equal to 200 cc of tissue.						
0398T	Magnetic resonance image guided high intensity focused ultrasound (mrgfus), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.	S**	1575	$11,483.38	J1	5463	$12,866.05
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance.	J1	5115	$12,593.29	J1	5115	$13,274.06

*Hospital Part B Services Paid Through a Comprehensive APC; aid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; all preventive services; and certain Part B inpatient services.
** Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment.

Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies

Effective January 1, 2020, CMS assigned three CPT codes (78431- 78433) describing services associated with cardiac PET/CT studies to New Technology APCs (APCs 1522, 1523, and 1523, respectively). CMS did not receive any claims data for these services for either of the CY 2021 or CY 2022 OPPS proposed or final rules. For CY 2023, CMS proposes to use CY 2021 claims data to determine the rates. The proposed APC placements are detailed in Table 12 of the proposed rule.

Table 12: Final CY 2022 and Proposed CY 2023 OPPS New Technology APC and Status Indicator Assignments for CPT Codes 78431, 78432, and 78433

CPT Code	Long Descriptor	Final CY 2022 OPPS SI	Final CY 2022 OPPS APC	Proposed CY 2023 OPPS SI	Proposed OPPS CY 2023 APC
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	S	1522	S	1523
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	S	1523	S	1520
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	S	1523	S	1521

Brachytherapy

Universal Low Volume APC Policy for Clinical and Brachytherapy APCs
In the CY 2022 HOPPS final rule with comment period, CMS adopted a universal Low Volume APC policy for CY 2022 and subsequent calendar. This policy states when a clinical or brachytherapy APC has fewer than 100 single claims that can be used for ratesetting, under the low volume APC payment adjustment policy CMS determines the APC cost as the greatest of the geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data. CMS proposes to designate four brachytherapy APCs and four clinical APCs as low volume APCs. The four brachytherapy APCs and four clinical APCs meet CMS's criteria of having fewer than 100 single claims in the claims year used for rate setting and therefore, CMS proposes that they would be subject to the low volume APC policy.

Table 24: Cost Statistics for Proposed Low Volume APCs Using Comprehensive (OPPS) Ratesetting Methodology for CY 2023

APC	APC Description	CY 2021 Claims Available for Rate Setting	Geometric Mean Cost without Low Volume APC Designation	Proposed Median Cost	Proposed Arithmetic Mean Cost	Proposed Geometric Mean Cost	Proposed CY 2023 APC Cost
2632	Iodine I-125 sodium iodide	9	$141.23	$31.74	$44.35	$37.26	$44.35
2635	Brachytx, non-str, HA, P-103	26	$125.24	$34.04	$51.09	$42.77	$51.09
2636	Brachy linear, non-str, P-103	0	---*	$49.65	$53.38	$38.80	$53.38
2647	Brachytx, NS, Non-HDRIr-192	14	$144.37	$184.49	$377.65	$141.48	$377.65

* For this proposed rule, there are no CY 2021 claims that contain the HCPCS code assigned to APC 2636 (HCPCS code C2636) that are available for CY 2023 OPPS/ASC ratesetting.

CT Lung Cancer Screening

In the CY 2023 HOPPS Proposed Rule, CMS proposes to place 71271 (Low Dose CT for Lung Cancer Screening) in APC 5522 with payment rate of $109.03. In addition, CMS proposes to place G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment rate of $76.98. The ACR has raised concerns about the inadequate payments for CT lung screening based on flawed hospital data in the past comment letters to CMS.

Supervision by Nonphysician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients

For CY 2023, to improve clarity, CMS proposes to replace cross references at § 410.27(a)(1)(iv)(A) and (B) and § 410.28(e) to the definitions of general and personal supervision at § 410.32(b)(3)(i) and (iii) with the text of those definitions. CMS also proposes to revise § 410.28(e) to clarify that certain nonphysician practitioners (NPPs) may supervise the performance of diagnostic tests to the extent they are authorized to do so under their scope of practice and applicable State law.

OPPS Payment for Software as a Service

In CY 2018, HeartFlow was the first other Software as a Service (SaaS) procedure for which CMS made separate payment under the OPPS. Since then, there have been several SaaS products that CMS has made payment for. From 2021 to 2022, CMS has reviewed and approved New Technology applications for the LiverMultiScan, Optellum, and QMRCP SaaS procedures. CMS proposes not to recognize the select CPT add-on codes that describe SaaS procedures under the OPPS. CMS states that despite the CPT Editorial Panel categorizing CPT codes 0649T, 0722T, and 0724T as add-on codes, these codes do not align with CMS's add-on code definition.

CY 2023 Proposal for SaaS Add-on Codes

CMS proposes to instead establish HCPCS codes, specifically, C-codes, to describe the add-on codes as standalone services that would be billed with the associated imaging service. CMS believes the payment for the proposed C-codes describing the SaaS procedures with add-on CPT codes, when billed concurrent with the acquisition of the images, should be equal to the payment for the SaaS procedures when the services are furnished without imaging and described by the standalone CPT code because the SaaS procedure is the same regardless of whether it is furnished with or without the imaging service.

For the LiverMultiScan service, CMS proposes not to recognize CPT code 0649T under the HOPPS and instead propose to establish C97X1 to describe the analysis of the quantitative magnetic resonance images that must be billed alongside the relevant CPT code describing the acquisition of the images. Below is the proposed long descriptor for the service:

- C97X1: Quantitative magnetic resonance analysis of tissue composition (e.g., fat, iron, water content), includes multiparametric data acquisition, preparation, transmission, interpretation and report, performed in the same session and/or same date with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure).

For the Optellum LCP service, CMS proposes not to recognize CPT code 0722T and instead propose to establish C97X2 to describe the use of Optellum LCP that must be billed alongside a concurrent CT scan. Below is the proposed long descriptor for the service:

- C97X2: Quantitative computed tomography (CT) tissue characterization, includes data acquisition, preparation, transmission, interpretation and report, performed in the same session and/or same date with concurrent CT examination of any structure contained in the acquired diagnostic imaging dataset.

For the QMRCP service, CMS proposes not to recognize CPT code 0724T and instead proposes to establish C97X3 to describe the use of QMRCP that must be billed alongside a concurrent CT scan. Below is the proposed long descriptor for the service:

- C97X3: Quantitative magnetic resonance cholangiopancreatography (QMRCP) includes data acquisition, preparation, transmission, interpretation and report, performed in the same session and/or same date with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure).

CMS is soliciting public comment on a payment approach that would broadly apply to SaaS procedures:

- How to identify services that should be separately recognized as an analysis distinct from both the underlying imaging test or the professional service paid under the PFS;
- How to identify costs associated with these kinds of services;
- How these services might be available and paid for in other settings (physician offices for example); and
- How CMS should consider payment strategies for these services across settings of care.

Additionally, CMS is seeking comments on the specific payment approach they may use for these services under the OPPS as SaaS-type technology becomes more widespread across healthcare which are not limited to imaging services.

ICRs for Addition of a New Service Category for Hospital Outpatient Department (OPD) Prior Authorization Process

CMS established a prior authorization process for certain hospital OPD services in the CY 2020 OPPS final rule, with additional service categories being added in the CY 2021 final rule. For CY 2023, CMS proposes to require prior authorization for a new service category: Facet Joint Interventions, effective for dates of service on or after March 31, 2023. The information collection requirement (ICR) associated with prior authorization requests is the required documentation submitted by providers. This includes all relevant documentation necessary to show that the service meets applicable Medicare coverage, coding, and payment rules and the request must be submitted before the service is provided to the beneficiary, and before the claim is submitted for processing. Table 83 in the proposed rule details the total burden and associated costs for the provisions.

Payment for Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Policy Packaged Drugs, Biologicals, and Radiopharmaceuticals

CMS currently pays for drugs, biologicals, and radiopharmaceuticals that do not have pass-through payment status in one of two ways: packaged into the payment for the associated service or separate payment (individual APCs). Hospitals do not receive a separate payment for packaged items and may not bill beneficiaries separately for any packaged items; these costs are recognized and paid within the OPPS payment rate for the associated procedure or service.

Threshold-packaged drugs under the OPPS are drugs, non-implantable biologicals and therapeutic radiopharmaceuticals whose packaging status is determined by the packaging threshold. If a drug's average

cost per day exceeds the annually determined packaging threshold, it is separately payable and, if not, it is packaged. For 2023, CMS proposes a packaging threshold for drugs, biologicals, and radiopharmaceuticals that are not new and do not have pass-through status of $135.

Payment Policy for Therapeutic Radiopharmaceuticals
For CY 2023, CMS proposes to continue paying for therapeutic radiopharmaceuticals at ASP+6 percent. For therapeutic radiopharmaceuticals for which ASP data are unavailable, CMS also proposes to determine 2023 payment rates based on 2021 geometric mean unit costs.

Other HOPPS Payment Policies

Proposed Payment Adjustments to Cancer Hospitals
The ACA requires an adjustment to cancer hospitals' outpatient payments to bring each hospital's payment-to-cost ratio (PCR) up to the level of the PCR for all other hospitals, the target PCR. The changes in additional payments from year to year are budget neutral. The 21st Century Cures Act reduced the target PCR by 1.0 percentage point and excludes the reduction from OPPS budget neutrality. The cancer hospital adjustment is applied at cost report settlement rather than on a claim-by-claim basis.

CMS proposes to use cost report data from the June 2020 HCRIS data set, which does not contain cost reports from CY 2020, given CMS's concerns with CY 2020 cost report data as a result of the COVID-19 PHE. For CY 2023, CMS proposes to continue to use the same target PCR they used for CY 2021 and CY 2022 of 0.89. This proposed CY 2023 target PCR of 0.89 includes the 1.0-percentage point reduction required by section 16002(b) of the 21st Century Cures Act for CY 2023.

Table 4 in the proposed rule shows the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals, with increases in OPPS payments for 2023 ranging from 12.9 percent to 69.2 percent. No additional budget neutrality adjustment is required for the cancer hospital adjustment in 2022 compared to 2021.

Table 4. The Estimated Percentage Increase in OPPS Payments to Each Cancer Hospital for CY 2023, Due to The Cancer Hospital Payment Adjustment Policy

Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2020 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	45.5%
050660	USC Norris Cancer Hospital	31.7%
100079	Sylvester Comprehensive Cancer Center	24.1%
100271	H. Lee Moffitt Cancer Center & Research Institute	23.1%
220162	Dana-Farber Cancer Institute	42.7%
330154	Memorial Sloan-Kettering Cancer Center	69.2%
330354	Roswell Park Cancer Institute	15.2%

360242	James Cancer Hospital & Solove Research Institute	12.9%
390196	Fox Chase Cancer Center	23.5%
450076	M.D. Anderson Cancer Center	49.4%
500138	Seattle Cancer Care Alliance	46.1%

Requirements for the Hospital Outpatient Quality Reporting (OQR) Program

Hospital OQR Program Quality Measures (p. 563)
CMS proposes no updates to the measures for the 2023 Hospital OQR performance year. The measures finalized in the 2022 Hospital Outpatient Prospective Payment System rulemaking process are planned for use during the 2023 and 2024 performance periods.

Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs
Continuing to prioritize the delivery of equitable care across all their programs, CMS proposes to expand efforts to report quality measure results stratified by patients' social risk factors and demographic variables. This proposed rule states that the Inpatient Prospective Payment System proposed rule for the fiscal year 2023 contains complete details on CMS' health equity considerations.

Public Display of Quality Measures
CMS proposes no changes to the policies regarding the public display of quality measures.

Requirements for the Rural Emergency Hospital Quality Reporting (REHQR) Program

Background (p. 625)
Under the Consolidated Appropriations Act (CAA), 2021, Congress established Rural Emergency Hospitals (REHs) as a new Medicare provider type. The Act defines REHs as facilities that, as of December 27, 2020, met the criteria for Critical Access Hospitals (CAHs) with 50 or fewer beds located in a county in a rural area or was a hospital with 50 or fewer beds, treated as being in a rural area. REHs must apply for enrollment in the Medicare program, provide emergency department services and observation care, and furnish services on an outpatient basis. However, they may not provide acute care inpatient services (with a limited exception if a particular unit is a licensed skilled nursing facility (SNF)).
The Act requires establishing quality measurement reporting requirements for REHs and may use claims-based measures and/or patient experience surveys. CMS analysis of data and external research suggests that there are a sufficient number of hospitals capable of converting into an REH. The characteristics of the hospitals that eventually convert may inform the quality measure selection for the quality reporting program by establishing that the measures are useable by REHs and have enough volume of services to allow meaningful measurement.

CMS acknowledges that regardless of the number of facilities that convert, there may be quality measure challenges due to the low numbers of hospitals and volume of services these facilities provide.

REHQR Program Quality Measures (p. 628)
CMS sought input from the public in the CY2022 OPPS proposed rule regarding concerns rural providers anticipate quality measurement and reporting requirements for REHs could pose. Common feedback comprised concerns regarding CMS' requirement that quality measures must be NQF endorsed for use in its quality programs, adoption of appropriate and meaningful measures, increased burden, and rural relevance. CMS also received feedback concerning the potential for low service and patient volume and ensuring health equity strategies.

Measure Endorsement: Given the dearth of endorsed measures for this particular facility setting, procedure, or other aspects of care, CMS will consider measures that are not NQF endorsed as long as they reflect a consensus among stakeholders during the development process, broad acceptance through use, and public comment.

Appropriate measure adoption: CMS describes its goals for adopting measures into the REHQR Program that will drive quality improvement (QI) efforts and that measure information is of sufficient volume for meeting case thresholds for facility level public reporting (via CMS' Compare website). They further propose that the finalized measures could already be adopted in the Hospital OQR Program. In other words, REHs currently participating in the Hospital OQR Program would already be reporting these measures with sufficient case threshold volumes.

Burden: CMS acknowledges that REHs are smaller hospitals with fewer resources than larger metropolitan-area hospitals. Due to rural facilities' common shortage of non-clinical staff responsible for collecting and reporting quality measures, CMS recognizes this and notes that measures necessitating staff resources (e.g., chart abstracted claims measures) would unlikely be proposed for the REH quality measure set. However, they note plans to limit the burden imposed by quality measure reporting while supporting this program and recognize that participation benefits may outweigh some costs.

Rural Relevance: Public input emphasized that the REHQR Program measures should reflect the services and care most frequently delivered in this particular setting while also aiming to improve inappropriate variation in care quality. To that end, CMS notes that they may propose measures for the REHQR Program that are topped out at the larger metropolitan hospitals but not at REH facilities.

Low Service and Patient Volume: CMS agrees with the public's concern regarding the selection of measures accommodating rural emergency hospitals that lack sufficient case volume to ensure that the performance rates for such measures are reliable. The proposed rule includes CMS' methods for ensuring this reliability.

Health Equity: Reducing disparities in health care is a top priority for CMS. Efforts are being made across programs to support equitable health care delivery. As in their other quality programs, CMS plans to examine disparities in health care delivery and quality by stratifying results of social vulnerability factors (e.g., patient dual eligibility) and patient demographic information, among others, to capture the breadth of social determinants of health in rural areas.

Request for Comment on Potential Measures for a REHQR Program (p. 636)
CMS proposes adopting measures into the REHQR Program recommended by the National Advisory Committee on Rural Health and Human Services. These measures are also reported under the Hospital OQR Program or the Health Resources and Services Agency's Medicare Beneficiary Quality Improvement Project (MBQIP). Of the measures recommended, *OP-10 Abdomen Computed Tomography (CT) - Use of Contrast Material* addresses radiology. CMS' rationale for including this measure explains that rural facilities account for 32.2 percent of all facilities reporting measures for the Hospital OQR Program, and that facilities account for 46 percent of the outliers for OP-10, thereby indicating variation and potential areas for targeted improvement.

CMS also seeks input on additional measurement topics and measures for the REHQR Program. Priority areas for rural communities include telehealth, emergency care services, and equity.

Inpatient Only List
The IPO list was created based on the premise that Medicare should not pay for procedures furnished as outpatient services that are not reasonable and necessary to be performed in any other setting than inpatient. In the CY 2022 final rule, CMS halted the elimination of the IPO list and, after clinical review of the services removed from the IPO list in CY 2021 as part of the first phase of eliminating the IPO list used the five codified criteria, CMS returned most of the services back to the list beginning in CY 2022.

For 2023, CMS proposes to remove 10 services from the Inpatient Only List, as well as add 8 newly created services. Table 46 in the rule details the proposed changes to the IPO list.

Changes to Beneficiary Coinsurance for Certain Colorectal Cancer Screening Tests
Medicare pays 100 percent of the payment amount for certain colorectal cancer screening tests that are recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Thus, a beneficiary pays no cost-sharing for these screening tests.

When the colorectal cancer screening test benefit category was enacted into law, the statute specifically provided that if, during the course of a screening flexible sigmoidoscopy or screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under Medicare Part B shall not be made for the screening flexible sigmoidoscopy, but rather shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal. The result was that beneficiaries faced unexpected coinsurance charges because the procedure was classified as a diagnostic test instead of a preventive service screening test.

Section 4104 of the ACA addressed this issue with respect to the deductible but not for any coinsurance that may apply. Section 122 of the CAA addresses this issue for the coinsurance by successively reducing, over a period of years, the percentage amount of coinsurance for which the beneficiary is responsible so that for services furnished on or after January 1, 2030, the coinsurance will be zero. The phased-in increases in the amount the Medicare program pays for these services on or after January 1, 2023 are as follows:

Year	Medicare Payment Percent	Beneficiary Coinsurance Percent
2023 – 2026	85	15
2027 – 2029	90	10
2030 and subsequent years	100	0

Request for Information on Use of CMS Data to Drive Competition in Healthcare Marketplaces
On July 9, 2021, the President issued an Executive Order on Promoting Competition in the American Economy (EO 14036). According to EO 14036, "robust competition is critical to preserving America's role as the world's leading economy," and "the American promise of a broad and sustained prosperity depends on an open and competitive economy." There are concerns that hospital mergers can result in reduced service lines and responsiveness to rural communities' needs, which is harmful to patients.

In response to the EO 14036's call for a "whole-of-government approach" to address excessive concentration, abuses of market power, unfair competition, and the effects of monopoly and monopsony, CMS is seeking information from the public on how data that CMS collects could be used to promote competition across the health care system or protect the public from the harmful effects of consolidation within healthcare.

Specifically, CMS seeks comments from the public on the following:

- What additional data that is already collected by form 855A (PECOS) would be helpful to release to the public and researchers, to help identify the impact of provider mergers, acquisitions, consolidations, and changes in ownership on the affordability and availability of medical care, and why?
- Do commenters suggest that CMS release data on any mergers, acquisitions, consolidations, and changes in ownership that have taken place for any additional types of providers beyond nursing facilities and hospitals? If so, for which types of providers?
- What additional information collected by CMS would be useful for the public or researchers who are studying the impacts of mergers, acquisitions, consolidations, or changes in ownership?

The ACR's HOPPS Committee and staff will review these changes and will draft comments during the 60-day comment period. Those comments are due to CMS by September 13th, 2022.