American College of Radiology™

Calendar Year 2024 Hospital Outpatient Prospective Payment System Final Rule

On November 2, 2023, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2024 Hospital Outpatient Prospective Payment System (HOPPS) final rule. The finalized changes are effective January 1st, 2024.

Conversion Factor Update

CMS will increase the conversion factor by 3.1 percent bringing it up to $ 87.382 for CY 2024. This increase is based on the hospital inpatient market basket percentage increase of 3.3 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a productivity adjustment of 0.2 percentage point. CMS will further 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 will calculate an overall budget neutrality factor of 0.9912 for wage index changes by comparing total estimated payments from simulation model using the FY 2024 IPPS wage indexes to those payments using the FY 2023 IPPS wage indexes, as adopted on a calendar year basis for the OPPS. CMS will also calculate an additional budget neutrality factor of 0.9997 to account for the policy to cap wage index reductions for hospitals at 5 percent on an annual basis. CMS will maintain the current rural adjustment policy, and therefore set the budget neutrality factor for the rural adjustment to be 1.0000.

Hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program will be subject to a further reduction of 2.0 percentage points. Hospitals that fail to meet the requirements will result in a conversion factor for CY 2024 of $ 85.687.

CMS finalized the proposal to use the typical data process of using the most updated cost reports and claims data available to set CY 2024 OPPS and ASC rates. The best available cost report data is ordinarily from 2 years prior to the calendar year that is the subject of rulemaking, which would be data extracted from the Healthcare Cost Report Information System (HCRIS) in December 2022, which would contain many cost reports ending in FY 2020 and 2021 based on each hospital's cost reporting period.

Estimated Impact on Hospitals

CMS estimates that OPPS expenditures, including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case mix will be approximately $88.9 billion, which is approximately $6.0 billion higher than estimated CY 2023 OPPS expenditures.

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PROPOSED AMBULATORY PAYMENT CLASSIFICATION GROUP POLICIES

Imaging Ambulatory Payment Classifications

CMS did not make 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 2024. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two times rule.

Finalized CY 2024 Imaging APCs

APC	Group Title	SI	CY 2023 Relative Weight	CY 2024 Relative Weight	CY 2023 Payment Rate	CY 2024 Payment Rate
5521	Level 1 Imaging without Contrast	S*	1.0151	0.9918	$86.88	$86.67
5522	Level 2 Imaging without Contrast	S	1.2488	1.2001	$106.88	$104.87
5523	Level 3 Imaging without Contrast	S	2.7285	2.6746	$233.52	$233.71
5524	Level 4 Imaging without Contrast	S	5.8787	6.0215	$503.13	$526.17
5571	Level 1 Imaging with Contrast	S	2.1071	2.0055	$180.34	$175.24
5572	Level 2 Imaging with Contrast	S	4.3048	4.1977	$378.43	$366.80
5573	Level 3 Imaging with Contrast	S	8.6551	8.7395	$740.75	$763.67

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

APC Exceptions to the 2 Times Rule

CMS sets 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 12, found below, lists the 22 APCs that CMS found to be exempt from the 2 times rule for 2024 based on CY 2022 available claims data. CMS found that APCs 5303 (Level 3 Upper GI Procedures) and 5822 (Level 2 Health and Behavior Servies) no longer violate the 2 times rule, therefore they were removed from the exceptions list. Three newly identified APCs with violations of the 2 times rule were added: APCs 5734 (Level 4 Minor Procedures), 5743 (Level 3 Electric Analysis of Devices), and APC 5791 (Level 1 Pulmonary Treatment).

Table 12. Final CY 2024 APC Exceptions to the 2 Times Rule

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
5572	Level 2 Imaging with Contrast
5612	Level 2 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5674	Level 4 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
5743	Level 3 Electronic Analysis of Devices
5791	Level 1 Pulmonary Treatment
5811	Manipulation Therapy
5821	Level 1 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Comprehensive APCs

In the final rule, CMS finalized additional Comprehensive APCs (C-APC) under the existing C-APC payment policy in CY 2024: C-APC 5342 (Level 1 Abdominal/Peritoneal/Biliary and Related Procedures) and C-APC 5496 (Level 6 Intraocular APC). Table 2 in the final rule lists the C-APCs for CY 2024.

Changes to New-Technology APCs

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). For CY 2024, CMS finalized the proposal to use CY 2022 claims data to determine the rates. The finalized APC placements are detailed in Table 17 of the final rule, found below.

CPT code 78431 had over 22,000 single frequency claims in CY 2022 with a geometric mean of $2300, which is below the cost band for the currently assigned APC 1523 (New Technology Level 23 with payment of $2501-3000). CMS finalized the proposal to reassign CPT code 78431 to APC 1522 (New Technology Level 22 with payment of $2001-2500) for CY 2024.

CPT code 78432 had only six single frequency claims in CY 2022. This is below the 100 claims per year threshold, so CMS proposed to apply the universal low volume APC policy by using the highest rate of the geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data. Using available claims data from CY 2021 and CY 2022, CMS found that the geometric mean cost was the highest at $1658, which is below the cost band for APC 1520 (New Technology Level 20 with payment of $1801-1900). CMS stated in the final rule their concerns with applying the universal low volume policy in this case, because it may result in even lower utilization of code 78432. Therefore, for CY 2024, CMS will use their equitable adjustment authority under section 1833(t)(2)(E) of the Act to maintain the New Technology APC assignment for CPT code 78432 as finalized in the CY 2023 HOPPS final rule for one additional year by assigning the code to New Technology APC 1520 with payment rate $1850.50.

CPT code 78433 had over 1200 single frequency claims in CY 2022. The geometric mean was $1960, which falls within the cost band for APC 1521 (New Technology Level 21 with payment of $1901-2000), which it is currently assigned. CMS will continue to assign CPT 78433 to APC 1521 for CY 2024.

Table 17: Proposed and Final CY 2024 OPPS New Technology APC and Payment Rates for Cardiac PET/CT CPT Codes 78431, 78432, and 78433

CPT Code	Long Descriptor	Proposed CY 2024 APC	Proposed CY 2024 Payment Rate	Final CY 2024 APC	Final CY 2024 Payment Rate
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	1522	$2250.50	1522	$2250.50
78432	Myocardial imaging, positron emission tomography (PET),	1518	$1650.50	1520	$1850.50

	combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability)				
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	1521	$1950.50	1521	$1950.50

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. For CY 2024, CMS finalized the proposal to designate the following five brachytherapy APCs as low volume APCs with claims data updated through June 20, 2023.

Table 46: Cost Statistics for Final Low Volume APCs Using Comprehensive (OPPS) Ratesetting Methodology for CY 2024

APC	APC Description	CY 2022 Claims Available for Rate Setting	Geometric Mean Cost without Low Volume APC Designation	Final Median Cost	Final Arithmetic Mean Cost	Final Geometric Mean Cost	Final CY 2024 APC Cost
2632	Iodine I-125 sodium iodide	0	---*	$31.74	$61.83	$41.06	**$61.83**

2635	Brachytx, non-str, HA, P-103	21	$97.56	$58.38	$60.78	$54.74	**$60.78**
2636	Brachy linear, non-str, P-103	1	$60.16	$22.17	$55.57	$32.95	**$55.57**
2642	Brachytx, stranded, C-131	82	$93.94	$76.36	$100.23	$79.27	**$100.23**
2647	Brachytx, NS, Non-HDRIr-192	2	$415.40	$201.69	$358.12	$166.75	**$358.12**

*For this rule, there are no CY 2022 claims that contain the HCPCS code assigned to APC 2632 that are available for CY 2024 OPPS/ASC ratesetting.

CT Lung Cancer Screening

In the CY 2024 HOPPS final rule, CMS placed CPT code 71271 (Low Dose CT for Lung Cancer Screening) in APC 5522 with payment rate of $104.87. In addition, CMS placed CPT code G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment rate of $85.01.

Supervision by Nonphysician Practitioners, Physician Assistants and Clinical Nurse Specialists of Cardiac, Intensive Cardiac and Pulmonary Rehabilitation Services Furnished to Outpatients

For CY 2024, to comply with the Bipartisan Budget Act of 2018 and to ensure consistency with final revisions to § 410.47 and § 410.49 in the CY 2024 PFS final rule, CMS is revising § 410.27(a)(1)(iv)(B)(1) to expand the practitioners who may supervise cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR) services to include nurse practitioners (NPs), physician assistants (Pas), and clinical nurse specialists (CNSs). CMS is also allowing for the direct supervision requirement for CR, ICR, and PR services to include virtual presence of the physician through audio video real-time communications technology (excluding audio-only) through December 31, 2024, and extend this policy to the nonphysician practitioners, that is NPs, Pas, and CNSs, who are eligible to supervise these services in CY 2024.

OPPS Payment for Software as a Service

CMS did not finalize the proposal to place CPT codes 0648T and 0649T that report Q-MR procedures into the APC 1505 with a payment rate of $350.50. (Many uses of Q-MR exist, including the product with the trade name LiverMultiScan.) Instead, CMS implemented the proposal with modifications. After taking public comments into account, CMS is using the equitable adjustment authority under section 1833(t)(2)(E) to continue to assign CPT codes 0648T and 0649T to APC 1511 (New Technology – Level 11) with a payment rate of $950.50.

CMS agreed with commenters that for both CPT codes 0648T and 0649T, they should wait for more claims data before adjusting the current payment rates for these services. For future rulemaking, CMS is considering whether specific adjustments to payment policies and rate calculations are necessary to more accurately and appropriately pay for these products and services across settings of care.

CMS finalized the proposals to continue to place all other listed SaaS codes in the same APCs for CY2024, as seen in the table below.

OPPS Software as a Service (SaaS) Procedures

CPT Code	Long Descriptor	Proposed CY 2024 APC	Proposed CY 2024 Payment Rate	Finalized CY2024 APC	Finalized CY2024 Payment Rate
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computer tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	1511	$950.50	1511	$950.50
0648T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1505	$350.50	1511	$950.50
0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target	1505	$350.50	1511	$950.50

	structure) (List separately in addition to code for primary procedure)				
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1508	$650.50	1508	$650.50
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)	1508	$650.50	1508	$650.50
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1511	$950.50	1511	$950.50
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	1511	$950.50	1511	$950.50

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 CY 2024, CMS finalized 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 2024, CMS will continue paying for therapeutic radiopharmaceuticals at ASP+6 percent. For therapeutic radiopharmaceuticals for which ASP data are unavailable, CMS will determine 2024 payment rates based on 2022 geometric mean unit costs.

OPPS Packaging Policy for Diagnostic Radiopharmaceuticals

Under the OPPS, CMS packages several categories of nonpass-through drugs, biologicals, and radiopharmaceuticals, regardless of the cost of the products. Diagnostic radiopharmaceuticals, which include contrast agents, are one type of product that is policy packaged under the category described by § 419.2(b)(15). Since this policy was implemented in 2008, CMS has received feedback on the concerns regarding the packaging of diagnostic radiopharmaceuticals. In the CY 2024 HOPPS proposed rule, CMS solicited comments on how the OPPS policy packaging policy for diagnostic radiopharmaceuticals has impacted beneficiary access. CMS also solicited comments on five potential approaches of reimbursement for diagnostic radiopharmaceuticals that would enhance beneficiary access, while maintaining the principles of the outpatient prospective payment system.

These approaches included:

- Paying separately for diagnostic radiopharmaceuticals with per-day costs above the OPPS drug packaging threshold of $140;
- Establishing a specific per-day cost threshold that may be greater or less than the OPPS drug packaging threshold;
- Restructuring APCs, including by adding nuclear medicine APCs for services that utilize high-cost diagnostic radiopharmaceuticals;

- Creating specific payment policies for diagnostic radiopharmaceuticals used in clinical trials; and
- Adopting codes that incorporate the disease state being diagnosed or a diagnostic indication of a particular class of diagnostic radiopharmaceuticals.

CMS received a significant number of comments in response, but there was not a general consensus among commenters as to the most effective way for CMS to reform its OPPS diagnostic radiopharmaceutical payment policy. Many commenters requested that CMS provide separate payment for diagnostic radiopharmaceuticals, but CMS received many different suggestions as to the best way to pay separately.

CMS stated in the final rule that since they believe this is a complex and vital issue, they will further consider the commenter's feedback on potential policy changes for future notice and comment rulemaking. CMS welcomes ongoing engagement from stakeholders on any potential solutions regarding future payment changes.

Requirements for the Hospital Outpatient Quality Reporting (OQR) Program

Hospital Outpatient Quality Reporting (OQR)Program
Hospital OQR Program Quality Measures
Within the CY 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Proposed Rule, CMS proposed to adopt the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) electronic quality measure (eCQM) beginning with the voluntary CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. Until now, the OQR Program has not mandated specific measures for reporting.

After considering many comments received regarding the measure, CMS is finalizing its proposal to adopt the Excessive Radiation Dose measure (an electronic clinical quality measure or eCQM) within the HOQR program with voluntary reporting beginning with the CY 2025 reporting period but has modified the **mandatory reporting period to begin 1 year later than proposed** with the CY 2027 reporting period/CY 2029 payment determination. CMS explained it is delaying the implementation of mandatory reporting based on the many public comments received, primarily related to various aspects of the reporting burden. CMS states it will continue to monitor and evaluate measure implementation and adjust the timeframe for mandatory reporting as necessary in future rulemaking.

As specified, the measure calculates the percentage of eligible CT scans that are considered out-of-range based on having excessive radiation dose or inadequate image quality, relative to evidence-based thresholds per the clinical indication for the exam. According to CMS, this

measure provides a metric for reducing unintentional harm to patients from CT scans.

Among the many comments CMS received regarding this measure, several were about the adoption and implementation of the Excessive Radiation eCQM, its specifications, and vendor software. Some supported the measure's intention to reduce "excessive radiation" dosing from CT monitoring and agreed that the adoption of this measure promotes alignment with the other CMS quality programs. CMS also received feedback from those concerned with the measure's "Calculated CT Global Noise" and "Calculated CT Size-Adjusted Dose" set thresholds as not representing meaningful quality indicators defined by international or national standards organizations and greatly oversimplifies the nature of image noise in clinical examinations, while several voiced concerns with the per-patient limit-based measure approach. These commenters recommended that CMS work with the imaging community to identify a reference value approach that would be based on patient distribution. Others communicated their concerns with the eCQM's implementation, particularly that the required software integration, maintenance, and management impose significant burdens on hospital outpatient departments. For instance, challenges with integrating the measure developer's software into facility EHR or EMR systems (i.e., the processes for aggregating data components, and the financial and administrative burden from implementation challenges and data component aggregation). Given these concerns, CMS will monitor the measure's implementation during voluntary reporting, with plans for future adjustments to the reporting requirements in future rulemaking.

Rural Emergency Hospital Quality Reporting (REHQR) Program
REHQR Program Quality Measures
As part of the 2023 Hospital Outpatient Prospective Payment System (HOPPS) rulemaking, CMS finalized the formation of the REHQR Program for hospitals with fewer than 51 beds located in rural areas. Participating in this quality reporting program requires REHs to submit quality measure data to CMS. In this proposed rule, CMS finalized the adoption and codification of several standard quality program reporting policies into the REHQR Program, including the addition and removal of quality measures. It also finalized the four proposed measures for the REHQR Program.

The four initial measures available for REHQR Program participation beginning in 2024, consisting of three claims-based measures and one chart-abstracted measure, are:

1. **Abdomen CT - Use of Contrast Material** (currently included in the OPQR Program) provides the percentage of CT abdomen and abdominopelvic studies performed with, and without contrast out of all CT abdomen studies performed (those with and without contrast).
    a. CMS received comments on the adoption of this quality measure for the REHQR Program which were largely supportive, considering the measure's use in the HOQR Program, although, some communicated concerns with the measure's use

of denominator exclusions rather than risk-adjustment strategies, which would not account for the clinical reasons providers may perform duplicate abdomen CTs.

2. Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients.
3. Facility 7 Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy.
4. Risk-Standardized Hospital Visits Within Seven Days After Hospital Outpatient Surgery.

Other HOPPS Payment Policies

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.

For CY 2024, CMS will transition from the target PCR of 0.89 used for CYs 2020 through 2023 and incrementally reduce the target PCR by an additional 1.0 percentage point for each calendar year, beginning with CY 2024, until the target PCR equals the PCR of non-cancer hospitals (required by section 16002(b) of the 21st Century Cures Act). CMS finalized the proposal to reduce the CY 2023 target PCR of 0.89 by 1 percentage point and set the cancer hospital target PCR of 0.88 for CY 2024. Table 6 in the final rule shows the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals, with increases in OPPS payments for 2024 ranging from 14.5 percent to 58.0 percent.

Table 6. Estimated CY 2024 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement

Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2024 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	58.0%
050660	USC Norris Cancer Hospital	34.2%
100079	Sylvester Comprehensive Cancer Center	41.9%
100271	H. Lee Moffitt Cancer Center & Research Institute	25.0%
220162	Dana-Farber Cancer Institute	43.1%
330154	Memorial Sloan-Kettering Cancer Center	58.1%

330354	Roswell Park Cancer Institute	19.1%
360242	James Cancer Hospital & Solove Research Institute	14.5%
390196	Fox Chase Cancer Center	20.8%
450076	M.D. Anderson Cancer Center	44.8%
500138	Seattle Cancer Care Alliance	39.4%

Hospital Price Transparency

The hospital price transparency regulations implement Section 2718(e) of the Public Health Service (PHS) Act, effective January 1, 2021, which requires hospitals each year to establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital. CMS finalized new changes to increase standardization of the hospital price transparency machine-readable file (MRF). Hospitals also must display their standard charge information by conforming to a CMS template layout, data specifications, and data dictionary.

To improve the automated accessibility of hospital standard charges information, CMS finalized a policy that requires hospitals to place a "footer" at the bottom of the hospital's homepage that links to the webpage that includes the MRF, as well as a policy requiring hospitals to ensure that a .txt file is included in the root folder of the publicly available website where the hospital posts its MRF. CMS also finalized a requirement that each hospital make a good faith effort to ensure the data in the MRF is true, accurate, and complete. Additionally, each hospital will be required in its MRF to affirm that the hospital, to the best of its knowledge and belief, has included all applicable standard charge information in accordance with the requirements of 45 CFR part 180 and that the information displayed is true, accurate, and complete as of the date indicated in the file.

CMS finalized several regulatory additions and modifications to its enforcement provisions at 45 CFR 180.70 to improve CMS enforcement of these policies as well as increase transparency:

- CMS may require submission of certification by an authorized hospital official as to the accuracy and completeness of the data in the machine-readable file and submission of additional documentation as needed to determine hospital compliance.
- Require hospitals to submit an acknowledgement of receipt of the warning notice in the form and manner and by the deadline specified in the notice of violation issued by CMS to the hospital.
- In the event CMS takes action to address hospital noncompliance and the hospital is determined by CMS to be part of a health system, CMS may notify health system leadership of the action and may work with health system leadership to address similar deficiencies for hospitals across the health system.

- CMS may publicize on the CMS website information related to: 1) CMS' assessment of a hospital's compliance; 2) Any compliance action taken against a hospital, the status of such compliance action, and the outcome of such compliance action; and (3) Notifications sent to health system leadership. CMS already currently releases information regarding hospitals issued civil monetary penalties.

CMS is finalizing a phased implementation timeline for these changes. The effective date of all the changes to the hospital price transparency regulations at 45 CFR part 180 will be January 1, 2024.

These finalized policies are estimated to increase burden on hospitals, including a one-time mean of $2787 per hospital, and a total national cost of $19,784,539. CMS believes that the benefits to the public and to hospitals themselves outweigh the burden imposed on hospitals.

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