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2024 Hospital Outpatient Prospective Payment System – Proposed Rule Summary

On Thursday, July 13, 2023, the Centers for Medicare & Medicaid Services (CMS) released the 2024 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule, which includes modest payment increases for radiation therapy services effective January 1, 2024. Comments on the proposed rule are due September 11, 2023.

In the Medicare hospital outpatient environment, hospital reimbursement is based on Ambulatory Payment Classifications or APCs. CMS assigns CPT codes to an APC based on clinical and resource use similarity. All services in an APC are reimbursed at the same rate. Cost data collected from OPPS claims are used to calculate rates. Certain services are considered ancillary, and their costs are packaged into the primary service. Packaged services do not receive separate payment. For example, in the hospital outpatient environment, imaging is not paid separately when reported with treatment delivery services.

Below is a summary of key issues impacting radiation oncology, including:

- Proposed Conversion Factor Update
- Proposed Use of Most Updated Claims Report Data for Ratesetting
- Ambulatory Payment Classifications (APC)
- Comprehensive Ambulatory Payment Classifications (C-APCs)
- Two-Times Rule Exception
- Brachytherapy Sources
- Hospital Outpatient Quality Reporting (OPQ) Program
- Proposed OPPS Payment for Dental Services
- Cancer Hospital Payment Adjustment
- Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals
- Applications Received for Device Pass-Through Status for CY 2023
- Proposed New Technology APCs
- Health Equity
- Rural Emergency Hospital Quality Reporting (REHQR) Program

Proposed Conversion Factor Update

CMS proposes increasing the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.8%. This increase factor is based on the hospital inpatient market basket percentage increase of 3.0% for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus a proposed 0.2% productivity adjustment.

Based on this update, CMS estimates that proposed total payments to HOPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2024 will be approximately $88.6 billion, an increase of $6 billion compared to 2023 HOPPS payments.

Proposed Use of Most Updated Claims Report Data for Ratesetting

For CY 2024 rate setting, CMS is proposing to use claims data from 2022 and the most updated cost report data available from the Healthcare Cost Report Information System (HCRIS), which includes data from 2021. This is the Agency's typical data process, unlike in recent years when older data needed to be used due to the impact of COVID-19.

Ambulatory Payment Classifications (APC)

CMS is proposing to make modest changes to the payment rates of traditional radiation oncology APCs in the 2024 HOPPS proposed rule. Below is a list of radiation oncology APCs with their proposed 2024 payment rates:

Radiation Oncology - Ambulatory Payment Classification Proposed 2024 Payment Rates				
APC	**Descriptor**	**2023 Rate**	**2024 Proposed Rate**	**% Change**
5611	Level 1 Therapeutic Radiation Treatment Preparation	$133.38	$133.96	0.4%
5612	Level 2 Therapeutic Radiation Treatment Preparation	$358.72	$363.73	1.4%
5613	Level 3 Therapeutic Radiation Treatment Preparation	$1,340.67	$1,356.63	1.2%
5621	Level 1 Radiation Therapy	$122.39	$118.64	-3.1%
5622	Level 2 Radiation Therapy	$262.93	$264.48	0.6%
5623	Level 3 Radiation Therapy	$572.47	$578.61	1.1%
5624	Level 4 Radiation Therapy - HDR Brachytherapy	$721.72	$710.32	-1.6%
5625	Level 5 Radiation Therapy - Proton Therapy	$1,323.22	$1,395.56	5.5%
5626	Level 6 Radiation Therapy - SBRT	$1,767.45	$1,776.23	0.5%

Comprehensive Ambulatory Payment Classifications (C-APCs)

Under the C-APC policy, CMS provides a single payment for all services on the claim regardless of the span of the date(s) of service. Conceptually, the C-APC is designed so there is a single primary service on the claim, identified by the status indicator (SI) of "J1". All adjunctive services provided to support the delivery of the primary service are included on the claim. While ASTRO supports policies that promote efficiency and the provision of high-quality care, we have long expressed concern that the C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC.

For 2024, CMS seeks to expand the Comprehensive Ambulatory Payment Classification (C-APC) methodology. While neither proposed revision directly impacts radiation oncology services, these proposals indicate that the Agency is still refining the C-APC methodology as it relates to certain services.

Below is a comparison table of the 2023 payment rates and proposed 2024 payment rates for the radiation oncology services in several key C-APCs:

C-APC 5627 Level 7 Radiation Therapy				
CPT Code	Descriptor	2023 Rate	2024Proposed Rate	% Change
77371	SRS Multisource	$7,690.57	$7,546.49	-1.9%
77372	SRS Linear Based	$7,690.57	$7,546.49	-1.9%
77424	IORT delivery by x-ray	$7,690.57	$7,546.49	-1.9%

77425	IORT delivery by electrons	$7,690.57	$7,546.49	-1.9%
C-APC 5092 Level 2 Breast/Lymphatic Surgery and Related Procedures				
19298	Place breast rad tube/caths	$5,943.15	$6,241.92	5.0%
C-APC 5093 Level 3 Breast/Lymphatic Surgery and Related Procedures				
19296	Place po breast cath for rad	$8,805.74	$9,022.47	2.5%
C-APC 5113 Level 3 Musculoskeletal Procedures				
20555	Place ndl musc/tis for rt	$2,976.66	$3,111.88	4.5%
C-APC 5165 Level 5 ENT Procedures				
41019	Place needles h&n for rt	$5,339.67	$5,583.19	4.6%
C-APC 5302 Level 2 Upper GI Procedures				
43241	Egd tube/cath insertion	$1,741.59	$1,833.10	5.3%
C-APC 5375 Level 5 Urology and Related Services				
55875	Transperi needle place pros	$4,702.18	$4,959.89	5.5%
C-APC 5415 Level 5 Gynecologic Procedures				
55920	Place needles pelvic for rt	$4,635.11	$4,783.96	3.2%
57155	Insert uteri tandem/ovoids	$4,635.11	$4,783.96	3.2%
58346	Insert heyman uteri capsule	$4,635.11	$4,783.96	3.2%

Although most radiation oncology services see a modest increase in the proposal, ASTRO remains concerned that these services are still undervalued due to the C-APC methodology. Despite efforts to encourage the Agency to value these services more accurately, CMS remains committed to the methodology and does not intend to modify it for radiation oncology services. ASTRO will continue to educate CMS on the impact the C-APC methodology has on radiation oncology services, particularly brachytherapy.

Two-Times Rule Exception

CMS established two-times rule criteria within the APC methodology that requires that the highest calculated cost of an individual procedure categorized to any given APC cannot exceed two times the calculated cost of the lowest-costing procedure categorized to that same APC. However, the Agency can exempt any APC from the two-times rule for any of the following reasons:

- Resource homogeneity
- Clinical homogeneity
- Hospital outpatient setting utilization
- Frequency of service (volume)
- Opportunity for upcoding and code fragments

Based on CY 2022 claims data, CMS proposes to apply the two-times rule exception to APC 5612 *Level 2 Therapeutic Radiation Treatment Preparation* APC 5627 *Level 7 Radiation Therapy*.

Brachytherapy Sources

In the 2024 HOPPS proposed rule, CMS is proposing to continue to base the payment rates for brachytherapy sources on the geometric mean costs for each source, which is consistent with the methodology used for other services under HOPPS. Additionally, the Agency will use the costs derived from 2022 claims data to set the proposed 2024 payment rates for brachytherapy sources because that is

the claims data used for most other items in the proposed rule. However, C2645 *Brachytherapy planar source, palladium-103, per square millimeter* had insufficient claims data, so the Agency proposes to continue the CY 2019 payment rate of $4.69 per mm^2 in CY 2024.

CMS proposes to pay for HCPCS codes C2698 *Brachytherapy source, stranded, not otherwise specified* and C2699 *Brachytherapy source, non-stranded, not otherwise specified*, at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively on a per source basis. For 2024, the proposed rates are $40.87 for C2698 and $36.44 for C2699. This is a 7.1% change in payment for C2698 and a 3.2% change for C2699 from the 2023 rates.

In the 2022 HOPPS final rule, CMS established a Low Volume APC policy for brachytherapy APCs (also for New Technology APCs and clinical APCs—it is universal). For those APCs with fewer than 100 single claims that can be used for rate setting purposes in the existing claims year, CMS uses up to four years of claims data to establish a payment rate for each item or service, which is a similar methodology that the Agency applies to low volume services assigned to New Technology APCs. Further, the Agency calculates the cost based on the greatest of the arithmetic mean cost, median cost, or geometric mean cost.

CMS is proposing to designate 5 brachytherapy APCs as Low Volume APCs for CY 2023 (See Table 27 below).

Table 27: Cost Statistics for Proposed Low Volume APCs Using Comprehensive (OPPS) Ratesetting Methodology for CY 2024

APC	APC Description	CY 2022 Claims Available for Ratesetting	Geometric Cost without Low Volume APC Designation	Proposed Median Cost	Proposed Arithmetic Mean Cost	Proposed Geometric Mean Cost	CY 2024 Proposed 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	$98.73	$58.38	$60.86	$54.77	$60.86
2636	Brachy linear, nonstr, P-103	1	$89.34	$22.17	$57.15	$33.66	$57.15
2642	Brachytx, stranded, C-131	76	$99.92	$79.90	$100.65	$79.90	$100.65
2647	Brachytx, NS, Non-HDRIr-192	2	$452.28	$201.69	$403.29	$167.08	$403.29

*For this proposed 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.

Hospital Outpatient Quality Reporting (OPQ) Program

For the Hospital OQR Program measure set, CMS proposes to, among other things, adopt the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) measure, beginning with CY 2025 reporting period on a voluntary basis, then shifting to mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.

Proposed OPPS Payment for Dental Services

For CY 2024, CMS proposes to assign 229 HCPCS codes describing dental services to various clinical APCs to align with Medicare payment provisions regarding dental services in the CY 2023 Medicare Physician Fee Schedule (MPFS) final rule. As in the MPFS, payment can be made only when the dental service is inextricably linked to other covered services. The Agency notes that HOPDs would only receive payment for a dental service assigned to an APC when the appropriate MAC determines that the service meets the relevant conditions for coverage and payment. It also anticipates that it would continue to assess its policies for OPPS payment for dental services in future rulemaking.

Cancer Hospital Payment Adjustment

Since the inception of OPPS, Medicare has paid the 11 hospitals that meet the criteria for "cancer hospitals" under OPPS for covered outpatient hospital services to reflect their higher outpatient costs. For CY 2024, CMS is proposing to continue providing additional payments to cancer hospitals so that a cancer hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data. Section 16002(b) of the 21st Century Cures Act requires that this weighted average PCR be reduced by 1.0%. Due to the PHE's impact on claims and cost data used to calculate the target PCR, CMS has maintained the CY 2021 target PCR of 0.89 through CYs 2022 and 2023.

In this proposed rule, the Agency proposes to reduce the target PCR by 1.0% each calendar year until the target PCR equals the PCR of non-cancer hospitals using the most recently submitted or settled cost report data. For CY 2024, it proposes to use a target PCR of 0.88 to determine the CY 2024 cancer hospital payment adjustment to be paid at cost report settlement. That is, the payment adjustments will be the additional payments needed to result in a PCR equal to 0.88 for each cancer hospital.

Cancer hospitals receive additional payments so that their payment-to-cost ratio (PCR) after the additional payment is equal to the weighted average PCR for other OPPS hospitals using the most recently submitted or settled cost report data. The actual final amount of the CY 2024 cancer hospital payment adjustment for each cancer hospital will be determined at cost report settlement and will depend on each hospital's CY 2024 payments and costs form the settled CY 2024 cost report. So, the actual increase for 2024 may end up being much less than estimated in this table.

In 1983, when the IPPS was established, Congress authorized CMS to develop regulations for exceptions to IPPS for hospitals involved extensively in cancer research and treatment. After HOPPS was created in 1999, these cancer hospitals received special treatment under it as well. Essentially, the Congressional action ensures that PPS Exempt Cancer Hospitals receive the same amount they would have received pre-HOPPS—they're permanently "held harmless."[1]

Table 5 below, excerpted from the proposed rule, shows the estimated percentage increase in OPPS payments to each cancer hospital for CY 2023, due to the cancer hospital payment adjustment policy.

[1] https://www.gao.gov/assets/gao-15-199.pdf

Table 5: 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	43.9%
050660	USC Norris Cancer Hospital	30.2%
100079	Sylvester Comprehensive Cancer Center	41.9%
100271	H. Lee Moffitt Cancer Center & Research Institute	25.0%
220162	Dana-Farber Cancer Institute	41.1%
330154	Memorial Sloan-Kettering Cancer Center	59.9%
330354	Roswell Park Cancer Institute	19.1%
360242	James Cancer Hospital & Solove Research Institute	11.6%
390196	Fox Chase Cancer Center	22.1%
450076	M.D. Anderson Cancer Center	47.7%
500138	Seattle Cancer Care Alliance	39.4%

Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals

Transitional pass-through payments are provided for certain "new" drugs and biologicals that were not being paid for as an HOPD service as of December 31, 1996, and whose cost is "not insignificant" in relation to the OPPS payments for the procedures or services associated with the new drug or biological. In the proposed rule, CMS clarifies that for pass-through payment purposes, radiopharmaceuticals are included as "drugs." Transitional pass-through payments for a drug can be made for a period of at least 2 years, but not more than 3 years, after the payment was first made for the drug as a hospital outpatient service under Medicare Part B.

Proposed Payment Policy for Therapeutic Radiopharmaceuticals

For CY 2024, CMS proposes to continue the payment policy for therapeutic radiopharmaceuticals that began in CY 2010. Medicare pays for separately payable therapeutic radiopharmaceuticals under the Average Sales Price (ASP) + 6% methodology adopted for separately payable drugs and biologicals. If ASP information is unavailable for a therapeutic radiopharmaceutical, CMS proposes to provide pass-through payment at weighted average cost (WAC) + 3%. If WAC information also is not available, the Agency proposes to provide payment for the pass-through radiopharmaceutical at 95% of its most recent average wholesale price (AWP).

Solicitation of Comments on OPPS Packing Policy for Diagnostic Radiopharmaceuticals

Under OPPS, CMS packages several categories of nonpass-through drugs, biologicals, and radiopharmaceuticals, regardless of the cost of the products. Interested parties have raised concerns regarding this policy for diagnostic radiopharmaceuticals, believing that the packaged payment rate is inadequate after pass-through status expires, especially when the diagnostic radiopharmaceutical is high-cost and has low utilization. Additionally, commenters have been concerned that packaging payment for precision diagnostic radiopharmaceuticals in the outpatient setting creates barriers to beneficiary access for safety net hospitals serving a high proportion of Medicare beneficiaries and hospitals serving underserved communities.

The Agency seeks comments on potential modifications to its packaging policy for diagnostic radiopharmaceuticals in order to ensure equitable payment and continued beneficiary access. It is also seeking comments on how the OPPS packaging policy for diagnostic radiopharmaceuticals has impacted

beneficiary access, including whether there are specific patient populations or clinical disease states for whom this issue is especially critical. It also asks for information on specific cost-prohibitive diagnostic radiopharmaceuticals that commenters believe are superior to alternative diagnostic modalities. The Agency is interested in learning about specific clinical scenarios for which it is only clinically appropriate to use the more expensive diagnostic radiopharmaceutical rather than the lower cost alternative, as well as clinical scenarios where the only diagnostic modality is a high-cost radiopharmaceutical.

Finally, CMS seeks comments on the following new approaches to payment of diagnostic radiopharmaceuticals under the OPPS:

1. Paying separately for diagnostic radiopharmaceuticals with per-day costs above the OPPS drug packaging threshold of $140;
2. Establishing a specific per-day cost threshold that may be greater or less than the OPPS drug packaging threshold;
3. Restructuring APCs , including by adding nuclear medicine APCs for services that utilize high-cost diagnostic radiopharmaceuticals;
4. Creating specific payment policies for diagnostic radiopharmaceuticals used in clinical trials; and
5. Adopting codes that incorporate the disease state being diagnosed or a diagnostic indication of a particular class of diagnostic radiopharmaceuticals.

New HCPCS Codes Effective July 1, 2023

For the July 2023 update, 97 new HCPCS codes were established and made effective on July 1, 2023. Through the July 2023 OPPS quarterly update, CMS recognized several new codes for separate payment and assigned them to appropriate interim OPPS status indicators and APCs.

In this proposed rule, CMS is soliciting comments on the proposed APC and status indicator assignments for the codes implemented on July 1, 2023 (those of interest to radiation oncology are listed in Table 7 below).

Table 7: New HCPCS Codes Effective July 1, 2023

CY 2023 HCPCS Code	CY 2023 Long Descriptor
0794T	Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately
0387U	Oncology (melanoma), autophagy and beclin 1 regulator 1 (AMBRA1) and loricrin (AMLo) by immunohistochemistry, formalin fixed paraffin-embedded (FFPE) tissue, report for risk of progression
0388U	Oncology (non-small cell lung cancer), next-generation sequencing with identification of single nucleotide variants, copy number variants, insertions and deletions, and structural variants in 37 cancer-related genes, plasma, with report for alteration detection
0391U	Oncology (solid tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded (FFPE) tissue, 437 genes, interpretive report for

	single nucleotide variants, splice site variants, insertions/deletions, copy number alterations, gene fusions, tumor mutational burden, and microsatellite instability, with algorithm quantifying immunotherapy response score
0395U	Oncology (lung), multi-omics (microbial DNA by shotgun next generation sequencing and carcinoembryonic antigen and osteopontin by immunoassay), plasma, algorithm reported as malignancy risk for lung nodules in early-stage disease
0397U	Oncology (non-small cell lung cancer), cell-free DNA from plasma, targeted sequence analysis of at least 109 genes, including sequence variants, substitutions, insertions, deletions, select rearrangements, and copy number variations

Applications Received for Device Pass-Through Status for CY 2023

CMS establishes specific criteria for hospitals to receive pass-through payments for devices that offer substantial clinical improvement in treatment of Medicare beneficiaries. Devices must meet the following criteria: 1) receive FDA approval or clearance; 2) the device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part; and 3) the device is an integral part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted, or applied in or on a wound or other skin lesion. Finally, the device must not be an item for which depreciation and financing expenses are recovered and it is not a supply or material furnished incident to a service.

In addition to meeting criteria for pass-through payment, a device must meet specific criteria for CMS to establish a new category of devices. The criteria for establishing a new category of devices require that the device is not appropriately described by any other category; and that it has an average cost that is not insignificant relative to the payment amount for the procedure or service with which the device is associated by demonstrating:

1) The estimated average reasonable costs of devices in the category exceeds 25% of the applicable APC payment amount for the service related to the category of devices;
2) The estimated average reasonable cost of the devices in the category exceeds the cost of the device-related portion of the APC payment about for the related service by at least 25%; and
3) The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount for the device exceeds 10% of the APC payment amount for the related service.

One pass-through application of interest to radiation oncology is Praxis Medical's CytoCore.
Per the applicant, at the time of biopsy, the motorized CytoCore device contains gears and an internal motor that spins a minimally invasive needle to increase cellular yields in fewer passes. The applicant further explained that CytoCore is vacuum-assisted and can easily be operated using one hand. According to the applicant, the primary use is for biopsy of any suspicious thyroid nodule.

Proposed New Technology APCs

Services that are assigned to New Technology APCs are typically new services that do not have sufficient claims history to establish an accurate payment for the services. One of the objectives of establishing New Technology APCs is to generate sufficient claims data for a new service so that it can be assigned to an appropriate clinical APC. Some services that are assigned to New Technology APCs have very low annual volume, which CMS considers to be fewer than 100 claims. It considers services with fewer than 100 claims annually to be low-volume services because there is a higher probability that the payment data for a service may not have a normal statistical distribution, which could affect the quality of its standard cost methodology that is used to assign services to an APC. In addition, services with fewer than 100 claims per year are not generally considered to be a significant contributor to the APC rate setting

calculations and, therefore, are not included in the assessment of the 2-times rule.

Where utilization of services assigned to a New Technology APC is low, it can lead to wide variation in payment rates from year to year, resulting in even lower utilization and potential barriers to access to new technologies, which ultimately limits the Agency's ability to assign the service to the appropriate clinical APC. To mitigate these issues, CMS decided it was appropriate to use its equitable adjustment authority to adjust how it determined the costs for low-volume services assigned to New Technology APCs. For New Technology APCs with fewer than 100 single claims at the procedure level that can be used for rate setting, CMS would apply its proposed methodology for determining a low volume APC's cost (as previously mentioned in the section on *Brachytherapy Services*), choosing the "greatest of" the median, arithmetic mean, or geometric mean at the procedure level, to apply to the individual services assigned to New Technology APCs and provide the final New Technology APC assignment for each procedure.

A procedure of interest to radiation oncology within the proposed New Technology APCs is *Bronchoscopy with Transbronchial Ablation of Lesion(s) by Microwave Energy*. Effective January 1, 2019, CMS established HCPCS code C9751 (Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (for example, aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s)). This microwave ablation procedure utilizes a flexible catheter to access the lung tumor via a working channel and may be used as an alternative procedure to a percutaneous microwave approach. Based on its review of the New Technology APC application for this service and the service's clinical similarity to existing services paid under the OPPS, the Agency estimated the likely cost of the procedure would be between $8,001 and $8,500.

In claims data available for CY 2019 for the CY 2021 OPPS/ASC final rule with comment period, there were four claims reported for bronchoscopy with transbronchial ablation of lesions by microwave energy. Given the low volume of claims for the service, CMS proposed for CY 2021 to apply the policy it adopted in CY 2019, under which it utilizes its equitable adjustment authority to calculate the geometric mean, arithmetic mean, and median costs to calculate an appropriate payment rate for purposes of assigning bronchoscopy with transbronchial ablation of lesions by microwave energy to a New Technology APC. The Agency found the geometric mean cost for the service to be approximately $2,693, the arithmetic mean cost to be approximately $3,086, and the median cost to be approximately $3,708. The median was the statistical methodology that estimated the highest cost for the service and provided a reasonable estimate of the midpoint cost of the three claims that have been paid for this service. The payment rate calculated using this methodology fell within the cost band for New Technology APC 1562 (New Technology—Level 25 ($3501– $4000)). Therefore, CMS assigned HCPCS code C9751 to APC 1562 for CY 2021.

For CY 2024, the only available claims for HCPCS code C9751 are from CY 2019. Therefore, CMS is proposing, given the low number of claims for this procedure, to again utilize its equitable adjustment authority. Because CMS is using the same claims as it did for CY 2021 and 2022, it found the same values for the geometric mean cost, arithmetic mean cost, and the median cost for CY 2024. Therefore, the payment rate calculated falls again within the cost band for New Technology APC 1562 (New Technology—Level 25 ($3501–$4000)), and the Agency proposes to continue to assign HCPCS code C9751 to APC 1562 (New Technology—Level 25 ($3501–$4000)), with a proposed payment rate of $3,750.50 for CY 2024. Details regarding HCPCS code C9751 are included in Table 11.

Table 11: CY 2022 Proposed OPPS APC and Status Indicator for HCPCS Code C9751 Assigned to New Technology APC

HCPCS Code	Long Descriptor	Proposed CY 2024 OPPS SI	Proposed CY 2024 OPPS APC	Proposed CY 2024 OPPS Payment Rate
C9751	Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]	T	1562	$3,750.50

Health Equity

CMS is seeking comment on how to structure an impact analysis that addresses how OPPS and ASC changes may impact beneficiaries of different groups. It currently presents OPPS impacts by provider type, rural versus urban area, geographic region, teaching status, and ownership type. The Agency is interested in what health equity questions it can examine within these existing categories to better understand the heath equity impact of our policies. It also welcomes suggestions about adding new categories or measures of health equity in its impact analyses, such as using the area deprivation index (ADI) as a proxy for disparities related to geographic variation. Additionally, it seeks comment on ways to continue building an OPPS health equity framework that allows it to develop policies that enhance health equity under our existing statutory authority.

Additional information about the 2024 HOPPS proposed rule can be found at the following links:

A display copy of the proposed rule can be found at:
https://public-inspection.federalregister.gov/2023-14768.pdf

The addenda relating to the HOPPS proposed rule are available at:
https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/hospital-outpatient-regulations-and/cms-1786-p

A fact sheet on this proposed rule is available at:
https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center