CY 2022 Medicare Hospital Outpatient Prospective Payment System (HOPPS)/Ambulatory Surgery Center (ASC) Final Rule (CMS-1753-FC)

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INTRODUCTORY SUMMARY AND BACKGROUND

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the Medicare Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgery Centers (ASC) for CY 2022.

CMS is required to annually review and update the payment rates for services payable under the Hospital Outpatient Prospective Payment System (HOPPS) and those payable in ASCs as specified in section 1833 of the Social Security Act. In addition, CMS is required to update the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program.

The prospective payment system (PPS) was developed and implemented to replace the reasonable cost-based payment methodology. The Hospital Outpatient Prospective Payment System (HOPPS) was implemented for services effective August 1, 2000. Under HOPPS, CMS pays for hospital Part B services on a rate-per-service basis according to the Ambulatory Payment Classification (APC) in which the service is assigned. The Healthcare Common Procedure Coding System (HCPCS), which includes Current Procedural Terminology (CPT®) codes, are used to identify and group the services within each APC. APCs are organized by similar clinical relevance and resource use. Special payments for new technology items and services under OPPS may be made by transitional pass-through payments and new technology APCs.

For ASCs, the surgical procedures on the ASC list for covered procedures are sorted into surgical specialty groups using CPT® and HCPCS code range definitions.

Certain hospitals are excluded from payment under HOPPS including critical access hospitals (CAHs); hospitals located in Maryland and paid under Maryland's All-Payer or Total Cost of Care Model; hospitals located outside the 50 states, the District of Columbia and Puerto Rico; and Indian Service (IHS) hospitals.

2022 HOPPS/ASC Final Rule

The CY 2022 final rule is located in its entirety at the following link:
https://www.federalregister.gov/public-inspection/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment.

This document in PDF form is 1,394 pages in length. The format of the information is intended to summarize the finalized changes so readers are encouraged to view the document in its entirety for further details.

HOPPS Payment Rates

There are approximately 3,659 facilities paid under HOPPS (including general acute care hospitals, children's hospitals, cancer hospitals, and community mental health centers (CMHCs). CMS is increasing payment rates under HOPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.0 percent. This increase is based on the final hospital inpatient market basket percentage increase of 2.7 percent reduced by a proposed productivity adjustment of 0.7 percentage point. Based on this update, CMS estimates total payments to OPPS for CY 2022 would be approximately $82.078 billion, an increase of approximately $5.913 billion from CY 2021 estimated OPPS payments.

Typically CMS would use the most updated claims and cost report data available to determine the OPPS and ASC rate setting. However, the CY 2020 claims data includes services provided during the COVID-19 PHE which significantly impacted outpatient service utilization. For this reason, CMS has determined CY 2019 claims data would be a better approximation for anticipated CY 2022 outpatient service utilization. Therefore, CMS is finalizing their proposal to use CY 2019 data to set CY 2022 OPPS and ASC payment rates.

Conversion Factor

To set the HOPPS conversion factor (CF) for CY 2022, CMS finalized the proposal to increase the CY 2021 conversion factor of $82.797 by 2.0 percent, while adjusting the conversion factor to ensure any revisions made to the wage index and rural adjustment were made on a budget neutral basis. The proposed overall budget neutrality factor is 1.0012 for wage index changes. Thus, the finalized CF for CY 2022 for hospitals that meet the hospital OQR program requirements is $84.457 in the calculation for national unadjusted rates. For those hospitals that fail to meet the hospital OQR program requirements, the CF is $82.810, which is a different in -1.647 in the CF relative to hospitals that meet the requirement.

Payment Rates

For CY 2022, CMS is finalizing HOPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.0 percent under the Outpatient Department (OPD) fee schedule. This update is based on the projected inpatient hospital market basket increase of 2.7 percent minus a 0.7 percentage point adjustment for multi-factor productivity (MFP). Based on this increase, the estimated total payments to HOPPS providers for CY 2022 will be $82.704 billion. This represents a $10.757 billion increase from estimated CY 2021 HOPPS payments.

CMS is also finalizing to continue implementing a statutory 2.0 percentage reduction for hospitals failing to meet the hospital outpatient quality reporting requirements set forth by the Hospital Outpatient Quality Reporting (OQR) Program. This is accomplished by applying a reporting factor of 0.9804 to the OPPS payments and copayments for all applicable services.

Wage Index

Under HOPPS, the wage index is an assigned value that is used when determining the reimbursement amount for any given code (CPT® or HCPCS) in a specific hospital or ASC. This value will vary depending on the geographic location of the hospital or ASC and whether it is designated as an urban or rural location. The wage index is then valued with the labor adjustments and the APC assigned values to calculate the overall reimbursement rate for the service in a specific geographic location.

When calculating the reimbursement for a particular service, the APC payment rate is multiplied by 60 percent of the labor-related share of the service and the wage index assigned per the geographic location of the hospital. This number is then added to the APC rate multiplied by 40 percent of the nonlabor related share of the work.

HOPPS wage index updates are proposed by CMS as part of the FY 2022 inpatient prospective payment system (IPPS) wage index adjustments and updated Office of Management and Budget (OMB) delineations. These changes are relative to the changes between urban and rural located hospitals. CMS is finalizing the proposal to implement a 5 percent cap on wage index decreases. This cap ensures the changes to be finalized are done to "soften" any wage index decreases that could have an overall impact to a specific value change.

CMS estimates the final rule update of the wage indexes (based on the FY 2022 IPPS proposed rule wage indexes) would result in no change for either urban hospitals or rural hospitals under HOPPS. For nonteaching hospitals, this update would result in an increased payment of 1.7 percent; minor teaching hospitals would result in increased payments of 1.6 percent; and major teaching hospitals would experience increased payments of 1.4 percent. These wage indexes include the continued implementation of the OMB labor market area delineations based on 2010 census data with updates.

For CY 2022, CMS is finalizing the proposal continue applying a wage index of 1.000 for frontier state hospitals (Montana, Wyoming, North Dakota, South Dakota, and Nevada) if the applicable wage index is less than 1.000. This policy has been in place since CY 2011. This ensures the lower population states are not "penalized" for reimbursement due to the low number of people per square mile when compared to other states.

Rural Adjustments

The rural adjustment factor of 7.1 percent to the HOPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs) was established in CY 2000 in a budget neutral manner. CMS is finalizing this proposal to continue this current policy in CY 2022. This will continue until data supports a different factor should be applied. This payment adjustment will continue to exclude separately payable drugs, biologicals, brachytherapy sources, items paid at charges reduced to cost, and devices paid under the pass-through payment policy.

Ambulatory Payment Classification (APC) Relative Payment Weights

It is required in Section 1833 of the Act to revise the relative payment weight for the APCs at least annually. APCs group services which are considered clinically comparable to each other in terms of resource utilization and associated cost. Ancillary services or items which are necessary components of the primary service are packaged into the APC rates and not separately reimbursed. Packaging encourages cost effectiveness and resource efficiency. CMS instructs providers to apply current procedure-to-procedure edits and then report all remaining services on the claim form.

CMS will only pay for those services which are considered not packaged into another service. Packaged services are those services that are integral, ancillary, supportive, dependent and adjunctive to the primary service. Under the current Comprehensive APC (C-APC) policy, CMS designates a service described by a CPT® or HCPCS code as the primary procedure when the service is identified by OPPS status indicator (SI) "J1". There are services which are not covered under the C-APC policy and will not be paid, including certain mammography and ambulance services; and services that are required to be separately paid, including brachytherapy seeds and pass-through payment drugs and devices.

For CY 2022, CMS is finalizing the proposal to continue the use of the C-APC payment policy methodology. Based on their review, CMS is finalizing to not convert any standard APCs to C-APCs in CY 2022. Therefore, the number of C-APCs would remain the same as in 2021, which is 69 C-APCs.

In addition to C-APCs, packaged services that are currently provided under the OPPS are reviewed annually in terms of integral, ancillary, supportive, dependent, or adjunctive items and services. For CY 2022, CMS is finalizing no changes to the overall packaging policy. This means the continuation of conditionally packaging the costs of selected newly identified ancillary services into payment for a primary service.

New and Revised Codes

As part of the rulemaking process, CMS reviews new CPT® and HCPCS codes and assigns each an interim status indicator (SI) and APC. CPT® and HCPCS code changes that affect HOPPS are published through the annual rulemaking cycle, as well as the HOPPS quarterly update Change Requests (CRs). A summary of the current process for updating coding through the HOPPS quarterly update CRs, seeking public comments and finalizing codes under HOPPS is listed in the table below:

TABLE 9: COMMENT TIMEFRAME FOR NEW AND REVISED HCPCS CODES

OPPS Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April 2021	HCPCS (CPT and Level II codes)	April 1, 2021	CY 2022 OPPS/ASC proposed rule	CY 2022 OPPS/ASC final rule with comment period
July 2021	HCPCS (CPT and Level II codes)	July 1, 2021	CY 2022 OPPS/ASC proposed rule	CY 2022 OPPS/ASC final rule with comment period
October 2021	HCPCS (CPT and Level II codes)	October 1, 2021	CY 2022 OPPS/ASC final rule with comment period	CY 2023 OPPS/ASC final rule with comment period
January 2022	CPT Codes	January 1, 2022	CY 2022 OPPS/ASC proposed rule	CY 2022 OPPS/ASC final rule with comment period
	Level II HCPCS Codes	January 1, 2022	CY 2022 OPPS/ASC final rule with comment period	CY 2023 OPPS/ASC final rule with comment period

Standardizing Ambulatory Payment Classifications (APCs) Payment Weights

CMS is finalizing the proposal to continue using HCPCS code *G0463 (Hospital outpatient clinic visits for assessment and management of a patient)* as the standardized code for the HOPPS relative payment weights in CY 2022; and will continue to be reimbursed a payment rate of 40 percent of the HOPPS rate for all off-campus

outpatient departments, excepted and nonexcepted. A relative weight payment of 1.00 was assigned to APC 5012 (G0463).

APC "2 Times Rule"

Items and services within an APC group cannot be considered resource utilization comparable if the highest mean cost for an item or service within the same APC group is more than 2 times greater than the lowest median cost. This is called the "2 times rule".

In the proposed rule, CMS identified 23 APCs in which the 2 times rule violation was found. The 2 times rule does not allow the codes to be assigned to an APC where the highest costing code is more than 2 times that of the lowest costing code. When a 2 times rule violation is identified, CMS and the HOP Panel will reassign codes or create a new APC. CMS only considers HCPCS codes that are significant based on the number of claims when determining if there is a 2 times rule violation. The following table lists the APCs identified in violation of the 2 times rule in which CMS is finalizing the proposal to make an exception for CY 2022:

TABLE 10: CY 2022 APC EXCEPTIONS TO THE 2 TIMES RULE

Proposed CY 2022 APC	Proposed CY 2022 APC Title
5051	Level 1 Skin Procedures
5055	Level 5 Skin Procedures
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5101	Level 1 Strapping and Cast Application
5112	Level 2 Musculoskeletal Procedures
5161	Level 1 ENT Procedures
5301	Level 1 Upper GI Procedures
5311	Level 1 Lower 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
5593	Level 3 Nuclear Medicine and Related Services
5612	Level 2 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5673	Level 3 Pathology
5691	Level 1 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5821	Level 1 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Device-Intensive Procedures

In the CY 2019 final rule and for subsequent years, CMS modified criteria for device-intensive procedures to potentially allow a greater number of procedures to qualify as device-intensive. In years' past, one of the main

criteria used to consider devices for device-intensive criteria only devices that remained in the patient (even temporarily) after the procedure. This is no longer a consideration. The modified criteria for device-intensive procedures is now in force:

- Procedure must involve implantable device assigned to a CPT® or HCPCS code;
- Device must be surgically inserted or implanted (either permanently or temporarily);
- Device offset amount must be significant, which is defined as exceeding 30 percent of the procedure's mean cost (down from 40 percent);
- Device has received FDA marketing authorization and investigational device exemption (IDE), and meets exemption from premarket review;
- Device is integral to the procedure performed;
- Device is used for one patient only; and
- Device comes into contact with human tissue.

CMS applied a 31 percent default offset to new HCPCS codes which describe procedures requiring a medical device implant but does not yet have claims data. Once claims data is available, CMS would be able to establish the HCPCS code-level device offset for procedures. The exception to this is in the case of a high-cost implantable device, which would be temporarily assigned a higher offset percentage if warranted by additional information. For example, pricing data could possibly come from the device manufacturer.

For CY 2022, CMS sought comments on their proposal to establish the CY 2022 device offset percentage using CY 2019 claims data when there is no data from CY 2020 for device-intensive procedures. For this process, 11 procedures have been identified in the proposed rule. Based on updated data for this final rule, CMS is applying device offset percentages from 2020 claims data to 14 procedures. These include the 11 procedures described previously in the proposed rule, plus three additional procedures that were assigned default device offset percentages for CY 2021 and have available device offset percentages from CY 2020 claims data.

In addition, CMS will continue recognition of HCPCS C1889 *(Implantable/insertable device, not otherwise classified)* for billing of the device as part of a device intensive procedure when there is no specific Level II HCPCS Category C-code to represent it.

Changes to the Inpatient Only List

Procedures and services typically provided in an inpatient setting and not paid by Medicare under HOPPS are identified in the inpatient only (IPO) list. This list was created to identify procedures that *"require inpatient care because of the invasive nature of the procedure, the need for at least 24 hours of postoperative recovery time, or the underlying physical condition of the patient who would require the surgery and, therefore, the service would not be paid by Medicare under the OPPS. For example, the list includes certain surgically invasive services on the brain, heart, and abdomen, such as craniotomies, coronary-artery bypass grafting, and laparotomies."*

Annual review of this list by CMS identifies services which should be removed or added based on the most recent data and medical evidence available, and the goal is to ensure inpatient only designations are consistent with current standards of practice. The current criteria used to determine if a procedure or service should be removed from the IPO and assigned to an APC group for payment under HOPPS includes:

1) Most outpatient departments are equipped to provide the services to the Medicare population;
2) The simplest procedure described by the code may be furnished in most outpatient departments;
3) The procedure is related to codes that have already been removed from the IPO list;
4) A determination is made that the procedure is being furnished in numerous hospitals on an outpatient basis;
5) A determination is made that the procedure can be appropriately and safely furnished in an ASC and is on the list of approved ASC services or has been proposed by us for addition to the ASC list.

Over the years, some stakeholders have requested to maintain the IPO list as a tool in which to ensure quality of care for Medicare beneficiaries. Other stakeholders have requested to eliminate the IPO list and defer to the clinical judgment of physicians for decisions regarding site of service. In CY 2021, CMS proposed and finalized the policy to eliminate the IPO list over a 3-year transitional period beginning on January 1, 2021, with the full list eliminated by January 1, 2024. 298 services and procedures (including 266 musculoskeletal) were removed from the IPO list.

For CY 2022, CMS is finalizing their proposal without modification to stop the elimination of the IPO list and add back the services removed in 2021 with some exceptions. CMS is also finalizing their proposal to codify the five longstanding criteria used to determine whether a procedure or service should be removed for the IPO list.

In addition, CMS sought feedback from stakeholders on multiple policy modifications including the continuation of eliminating the IPO list; or maintaining the IPO list with inpatient only designation procedures being consistent with current standards of practice. CMS will consider all comments received for future rulemaking.

The full list of IPO services is provided by CMS on their website in Addendum E, part of the 2022 NFRM OPPS Addenda or Table 48 of the final rule. The table contains the list of services to be added back to the IPO list. Of interest is code 37182, which was removed from the IPO list in CY 2021 and assigned to APC 5193. For CY 2022, this code is now back on the IPO list:

Addendum E.- HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2022			
HCPCS Code	**Short Descriptor**	**Comment Indicator**	**Status Indicator**
37182	Insert hepatic shunt (tips)	CH*	C

*CH = Active HCPCS code in current year and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that will be discontinued at the end of the current calendar year.

Ambulatory Surgery Center (ASC) Payment Rates

For Ambulatory Surgery Center (ASC) payments CY 2019 through 2023, CMS has updated their policy for using a market basket update to calculate rates. For CY 2022, CMS is finalizing an increase of 2.0% for ASCs that meet quality reporting under the Ambulatory Surgical Center Quality Reporting (ASCQR) program. This update is based on the projected hospital market basket increase of 2.7 percent minus a 0.7 percentage point adjustment for multi-factor productivity (MFP).

In addition, CMS is finalizing its proposal to adjust the conversion factor (CF) by the proposed wage index budget neutrality factor of 0.9997 in addition to the projected productivity-adjusted hospital market basket update of 2.3 percent, which results in a CY 2022 ASC CF of $50.043 for ASCs meeting the ASCQR program. For those ASCs

who do not meet the ASCQR program, the finalized CF is $48.937. CMS projects total payments to ASCs will be approximately $5.41 billion, a decrease of approximately $40 million compared to CY 2021 payments.

Surgical Procedures Designated as Temporarily Office-Based

CMS annually reviews and updates the covered procedures for which ASC payment is made, including those procedures which may be appropriate for ASC payment and those procedures which may be designated as office based. Of those procedures designated as office-based, they can either be permanent (being performed predominately in physicians' offices, i.e., more than 50 percent of the time); or temporary (designated as such in the CY 2019/CY 2020 final rules or fewer than 50 claims for procedure in data reviewed). CMS uses payment indicators as part of this designation:

- G2 – Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
- P2 – Office-based surgical procedure added to ASC list in CY 2008 or later with Medicare Physician Fee Schedule (MPFS) nonfacility practice expense (PE) relative value units (RVUs); payment based on OPPS relative payment weight.
- P3 – Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
- R2 – Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.

Typically, CMS would use the most updated claims and cost report data available to determine the OPPS and ASC rate setting. However, the CY 2020 claims data includes services provided during the COVID-19 PHE which significantly impacted outpatient service utilization. For this reason, CMS is not proposing to review CY 2020 claims data. Instead, CMS has finalized the proposal to not to assign permanent office-based designations for CY 2022 to any covered surgical procedure currently assigned a payment indicator of "G2". Similarly, CMS has also finalized to continue to designate covered surgical procedures currently assigned a payment indicator of "P2", "P3" or "R2". Of interest are codes 92985 and 93986, which have a payment indicator of P2.

TABLE 58: CY 2022 PAYMENT INDICATORS FOR ASC COVERED SURGICAL PROCEDURES DESIGNATED AS TEMPORARILY OFFICE-BASED

CY 2022 CPT/HCPCS Code	CY 2022 Long Descriptor	CY 2021 ASC Payment Indicator	CY 2022 ASC Payment Indicator*
93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	P2	P2*
93986	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study	P2	P2*

*Payment indicators are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the CY 2022 PFS final rule.

For these two codes, payment is based on their OPPS relative weight rather than MPFS nonfacility PE RVU-based amount.

Changes to the List of ASC Covered Surgical Procedures

CMS is required to review and update the ASC covered procedure list (ASC CPL) annually to determine whether procedures should be added or removed from the list. This process is often made in response to comments and concerns expressed by stakeholders. However, there are general "exclusion" criteria used in the determination for surgical procedures that:

1) Generally result in extensive blood loss;
2) Require major or prolonged invasion of body cavities;
3) Directly involve major blood vessels;
4) Are generally emergent or life threatening in nature;
5) Commonly require systemic thrombolytic therapy;
6) Are designated as requiring inpatient care under the e-CFR;
7) Can only be reported using a CPT unlisted surgical procedure code; or
8) Are otherwise excluded in the regulations.

In the 2021 HOPPS/ASC final rule, CMS significantly revised the policy for the addition of surgical procedures to the ASC CPL. 267 surgical procedures were added to the ASC PCL. Since that time, the policy has been re-examined, taking into consideration public comments and concerns from stakeholders. An internal clinical review of the 267 procedures added was conducted and CMS reconsidered the policy revisions.

As a result of the comments, CMS has determined a total of 6 procedures should remain or be added to the CPL. For CY 2022, CMS is finalizing its proposal to re-adopt the ASC PCL criteria that was in effect in CY 2020; and to remove 255 of the 267 procedures that were added to the ASC CPL in CY 2021. Procedures of interest that are proposed to be removed are listed in the following table:

TABLE 62: SURGICAL PROCEDURES FINALIZED FOR REMOVAL FROM THE LIST OF ASC COVERED SURGICAL PROCEDURES FOR CY 2022

CY 2022 CPT/HCPCS Code	CY 2022 Long Descriptor	Final CY 2022 ASC Payment Indicator
36838	Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	X5*
37183	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)	X5*
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	X5*
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	X5*

*X5 = Unsafe surgical procedure in ASC. No payment made.

CMS is also finalizing the proposal to change the notification process adopted in CY 2021 to a nomination process, under which stakeholders could nominate procedures they believe meet the requirements to be added to the ASC CPL. The formal nomination process would begin in CY 2023.

Updates to the Hospital Price Transparency Rule

Section 2718 of the Public Health Service Act (PHS Act) requires each hospital operating in the United States to establish, update and make public a list of the hospital's standard charges for items and services provided by the hospital. This includes diagnosis-related groups (DRGs). The Secretary is required to make known regulations to enforce the requirements of the PHS Act, which includes possible penalties.

CMS implemented these sections in the Federal Register, the final rule entitled *"*CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public*"* (84 FR 65524, November 27, 2019). This is now referred to as the "CY 2020 Hospital Price Transparency final rule". They adopted requirements for hospitals to make their standard charges public in two ways: (1) as a comprehensive machine-readable file; and (2) in a consumer-friendly format. These requirements were codified in 45 CFR part 180.

For CY 2022, CMS is finalizing amendments to the hospital price transparency policies to encourage compliance, including:

- Increasing the amount of the civil monetary penalty (CMP) for noncompliance through the use of a proposed scaling factor based on hospital bed count;
- Deeming state forensic hospitals that meet certain requirements to be in compliance with the requirements of 45 CFR part 180; and
- Requiring a machine-readable file be accessible to automated searches and direct downloads.

CMS has also clarified the expected output of hospital online price estimator tools when hospitals choose to use an online price estimator tool in lieu of posting its standard charges for the required shoppable services in a consumer-friendly format.

In addition, CMS sought comments on a variety of issues that they may consider in future rulemaking, including input for future consideration related to the price estimator tool policies; identifying best practices; common features, and solutions to overcoming common technical barriers; whether there should be a requirement for specific plain language standards, and, if so, what those plain language standards should be; potential ways CMS could highlight stellar hospital price transparency practices; and recommendations for improving standardization of the machine-readable file. CMS received approximately 396 timely comments.

Comment Solicitation on Temporary Policies for the PHE for COVID-19

In response to the COVID-19 pandemic, CMS issued wavers and provided rulemaking to implement a number of flexibilities to address the pandemic, such as preventing spread of the infection and supporting diagnosis of COVID-19.

While many of these waivers and policies will expire at the conclusion of the PHE, CMS sought comment on whether there are certain policies that should be made permanent. Specifically, mental health services furnished by hospital staff to beneficiaries in their homes through use of communication technology; direct supervision when the supervising practitioner is available through two-way, audio/video communication

technology; and the need for specific coding and payment for COVID-19 testing. CMS will consider all comments received for future rulemaking.