Calendar Year 2020 Hospital Outpatient Prospective Payment System Proposed Rule

On August 3rd, 2020 the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2020 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. This rule provides for a 60-day comment period ending on October 5, 2020. CMS is waiving the 60-day delay due to the COVID-19 public health emergency (PHE). Typically, the final rule would be published in early November to allow for a 60-day delay in the effective date in accord with the Congressional Review Act. CMS expects to provide a 30-day delay in the effective of the final rule which means that it would likely be published no later than December 2, 2020. The finalized changes are effective January 1, 2021.

Conversion Factor

CMS proposes to increase the conversion factor by 2.6 percent bringing it up to $ 83.697 for CY 2021. CMS determined the proposed conversion factor with the use of the proposed OPD fee schedule increase factor of 2.6 percent for CY 2021, the required proposed wage index budget neutrality adjustment of approximately 1.0017, the proposed cancer hospital payment adjustment of 1.000, and the proposed adjustment of 0.05 percentage point of projected OPPS spending for the difference in pass-through spending. This resulted in a proposed conversion factor for CY 2021 of $ 83.697. The proposed update equals the market basket of 3.0 percent reduced by a multifactor productivity adjustment of 0.4 percentage points.

CMS proposes that hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program would be subject to a further reduction of 2.0 percentage points. Hospitals that fail meet the requirements would result in a conversion factor for CY 2021 of $ 82.0650.

Estimated Impact on Hospitals

CMS estimates that OPPS expenditures, including beneficiary cost-sharing, will be approximately $83.9 billion, which is approximately $7.5 billion higher than estimated OPPS expenditures in 2020.

PROPOSED AMBULATORY PAYMENT CLASSIFICATION GROUP POLICIES

APC Placement of New Radiology CPT Codes

In March 2020, the ACR presented CMS with recommendations for new CPT codes within APCs for CY 2021. The table below shows CMS's proposed APC placement for CY 2021. CMS did agree with ACR's recommendation to place 324X0 (Core ndl bx lng/med perq) into APC 5072 (Level 2 Excision/ Biopsy/ Incision and Drainage) with a payment rate of $1,428.38. Conversely, CMS did not agree with ACR's recommendation to place the new lung cancer screening code 712X0 in APC 5523 (Level 3 Imaging without Contrast) with a payment rate of $235.05. Instead, CMS has proposed to place 712X0 in APC 5521 (Level 1 Imaging without Contrast).

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CMS Proposed APC Placement for New CPT Codes

CPT Code	Description	ACR Recommendation APC Placement	CY 2021 Proposed APC Placement	CY 2021 Proposed Payment Rate
324X0	Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed (Do not report 324X0 in conjunction with 76942, 77002, 77012, 77021)	5072	5072	$1,428.38
712X0	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	5523	5521	$82.15

Imaging APCs
CMS does not propose any new changes to the APC structure for imaging codes. The seven payment categories remain. However, CMS has moved codes within these payment categories which would chang pricing for 2021. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two-times rule.

Proposed CY 2021 Imaging APCs

APC	Group Title	SI	Relative Weight	CY 2020 Payment Rate	CY 2020 Proposed Payment Rate
5521	Level 1 Imaging without Contrast	S*	0.9815	$79.80	$82.15
5522	Level 2 Imaging without Contrast	S	1.3309	$112.07	$111.39
5523	Level 3 Imaging without Contrast	S	2.8084	$233.01	$235.05
5524	Level 4 Imaging without Contrast	S	5.8607	$481.53	$490.52
5571	Level 1 Imaging with Contrast	S	2.1675	$182.20	$181.41
5572	Level 2 Imaging with Contrast	S	4.4844	$381.81	$375.33
5573	Level 3 Imaging with Contrast	S	8.6352	$680.74	$722.74

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

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

For 2021, CMS notes that in many cases, the proposed procedure code reassignments and associated APC configurations are related to changes in costs of services that were observed in the 2019 claims data. Table 9, found below, lists the 18 APCs that CMS proposes to be exempt from the 2-times rule for 2021 based on claims data from January 1, 2019, through December 31, 2019 and processed on or before December 31, 2019. For the final rule, CMS plans to use claims data for dates of service from January 1, 2019 to December 31, 2019 that were processed on or before June 30, 2020 and updated CCRs, if available.

Table 9. Proposed APC Exceptions to the 2 Times Rule for 2021

2021 APC	APC Title
5051	5051 Level 1 Skin Procedures
5055	5055 Level 5 Skin Procedures
5071	5071 Level 1 Excision/ Biopsy/ Incision and Drainage
5112	5112 Level 2 Musculoskeletal Procedures
5301	5301 Level 1 Upper GI Procedures
5311	5311 Level 1 Lower GI Procedures
5521	5521 Level 1 Imaging without Contrast
5522	5522 Level 2 Imaging without Contrast
5523	5523 Level 3 Imaging without Contrast
5524	5524 Level 4 Imaging without Contrast
5571	5571 Level 1 Imaging with Contrast
5612	5612 Level 2 Therapeutic Radiation Treatment Preparation
5627	5627 Level 7 Radiation Therapy
5691	5691 Level 1 Drug Administration
5721	5721 Level 1 Diagnostic Tests and Related Services
5731	5731 Level 1 Minor Procedures

Comprehensive APCs

For CY 2021, CMS proposes to create two new comprehensive APCs (C-APCs). These proposed new C-APCs include the following: C-APC 5378 (Level 8 Urology and Related Services) and C–APC 5465 (Level 5 Neurostimulator and Related Procedures). Adding these C-APCs would increase the total number of C-APCs to 69.

Changes to New-Technology APCs

Proposed Changes to MRgFUS

There are currently four CPT/HCPCS codes that describe magnetic resonance image-guided,

high-intensity focused ultrasound (MRgFUS) procedures, three of which CMS proposes to continue assigning to standard APCs, and one that CMS proposes to continue to assign to a New Technology APC for CY 2021. These codes include CPT codes 0071T, 0072T, and 0398T, and HCPCS code C9734. Based on available 2019 claims data, CMS has identified 149 paid claims for CPT code 0398T (MRgFUS for treatment of essential tremors) with a geometric mean of $12,798.38. Since the service no longer meets the definition for a low-volume new technology service, CMS proposes to assign the service to a clinical APC. Based on the 2019 claims, CMS determined that the most appropriate APC would be the Neurostimulator and Related Procedures APC series (APC 5461- 5464). Based on the geometric mean cost of CPT code 0398T ($12,798.38), CMS is concerned that the payment rate for APC 5462 ($6,169.27) would be too low and the payment rate for APC 5463 would be too high ($19,737.37) for this procedure. CMS proposes to restructure this APC family and create an additional payment level within the clinical APC family. CMS proposes to create a Level 3, "Proposed APC 5463", with a payment rate of approximately $12,286. CMS proposes to reassign CPT code 0398T to "Proposed APC 5463."

Table 10. Proposed CY 2021 Status Indicator (SI), APC Assignment, And Payment Rate for the MRgFUS Procedures

CPT/ HCPCS Code	Long Descriptor	CY 2020 OPPS SI	CY 2020 OPPS APC	CY 2020 OPPS Payment Rate	Proposed CY 2021 OPPS SI	Proposed CY 2021 OPPS APC	Proposed CY 2021 OPPS Payment Rate
0071T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume less than 200 cc of tissue.	J1*	5414	$ 2,497.83	J1	5414	$2,664.86
0072T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume greater or equal to 200 cc of tissue.	J1	5414	$ 2,497.83	J1	5414	$2,664.86
0398T	Magnetic resonance image guided high intensity focused	S**	1575	$12,500.50	J1	5463	$12,780.91

	ultrasound (mrgfus), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.						
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance.	J1	5115	$11,899.39	J1	5115	$12,558.56

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

Brachtherapy
Since 2010, CMS has used the standard OPPS payment methodology for brachytherapy sources, with payment rates based on source-specific costs as required by statute. CMS proposes no changes to their brachytherapy policy for 2021.

CT and MR Cost Centers
Beginning in CY 2021, CMS proposes to fully implement the CT and MR cost data regardless of the cost allocation method. The ACR has raised concerns many times in the past regarding the use of claims from hospitals that continue to report under the "square foot" cost allocation method noting that it would underestimate the true costs of CT and MR studies. CMS has given the hospitals six years to adjust their cost allocation methods from "square foot" to either the "direct" or the "dollar" method. These changes are the result of a study conducted by the Research Triangle Institute (RTI) back in 2007[1]. Although the ACR has argued that the RTI study, and data which back it up, are outdated, CMS is adamant to continue with fully implementing its recommendations on how to better represent cost center data in the hospital setting.

[1] Cromwell, J., & Dalton, K. (2007, January). *A Study of Charge Compression in Calculating DRG Relative Weights* (Rep.). Retrieved July 1, 2019, from Centers for Medicare and Medicaid Services website: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Dalton.pdf

Table 1 of the proposed rule shows the relative effect on imaging APC payments after removing cost data for providers that report CT and MRI standard cost centers using square feet as the cost allocation method. Table 2 of the proposed rule provides statistical values based on the CT and MRI standard cost center CCRs using the different cost allocation methods. Tables 1 and 2 are shown below.

Table 1. Percentage Change in Estimated Cost for CT and MRI APCS When Excluding Claims From Provider Using "Square Feet" As the Cost Allocation Method

APC	APC Descriptor	Percentage Change
5521	Level 1 Imaging without Contrast	-2.6%
5522	Level 2 Imaging without Contrast	5.5%
5523	Level 3 Imaging without Contrast	4.1%
5524	Level 4 Imaging without Contrast	5.5%
5571	Level 1 Imaging with Contrast	6.7%
5572	Level 2 Imaging with Contrast	8.3%
5573	Level 3 Imaging with Contrast	2.1%
8007	MRI and MRA without Contrast Composite	7.0%
8008	MRI and MRA with Contrast Composite	7.3%
8007	MRI and MRA without Contrast Composite	7.0%
8008	MRI and MRA with Contrast Composite	7.3%

Table 2. CCR Statistical Values Based on Use of Different Cost Allocation Methods

Cost Allocation Method	CT		MR	
	Median CCR	Mean CCR	Median CCR	Mean CCR
All Providers	0.0347	0.0491	0.0764	0.1016
Square Feet Only	0.0286	0.0444	0.0665	0.0928
Direct Assign	0.0472	0.0564	0.0935	0.1183
Dollar Value	0.0414	0.0553	0.0858	0.1128
Direct Assign and Dollar Value	0.0415	0.0555	0.0866	0.1131

Furthermore, CMS will continue to monitor OPPS imaging payments and consider the potential impacts of payment changes on the physician fee schedule (PFS) and ambulatory surgical center payment systems.

CT Lung Cancer Screening

In the CY 2021 HOPPS Proposed Rule, CMS proposes placing 712X0 (Low Dose CT for Lung Cancer Screening) in the lowest Imaging without Contrast APC (5521), with payment rate of $82.15. In addition, CMS proposes to place G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment rate of $75.26. The ACR has raised concerns about the inadequate payments for CT lung screening based on flawed hospital data in the past comment letters to CMS.

Policy Packaged Drugs, Biologicals, and Radiopharmaceuticals
CMS proposes to continue paying for drugs and therapeutic radiopharmaceuticals at ASP + 6% as set forth in the CY 2010 HOPPS Final Rule. CMS proposes to maintain the threshold payment for therapeutic radiopharmaceuticals at $130, where CMS will package those that are priced less or equal to $130 into the APC payments and pay separately for those that meet or exceed this threshold amount.

Other HOPPS Payment Policies

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

The cancer hospital adjustment is applied at cost report settlement rather than on a claim by claim basis. For 2021, CMS updated its calculations using the latest available cost data and proposes a target PCR of 0.90. CMS proposes reducing the target PCR from 0.90 to 0.89. Table 6, below, shows the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals, with increases in OPPS payments for 2021 ranging from 11.2 percent to 44.8 percent. No additional budget neutrality adjustment is required for the cancer hospital adjustment in 2021 compared to 2020.

Table 5. The Estimated Percentage Increase in OPPS Payments to Each Cancer Hospital For CY 2021, Due To The Cancer Hospital Payment Adjustment Policy

Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2020 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	32.8%
050660	USC Norris Cancer Hospital	11.2%
100079	Sylvester Comprehensive Cancer Center	12.8%
100271	H. Lee Moffitt Cancer Center & Research Institute	20.5%
220162	Dana-Farber Cancer Institute	35.8%
330154	Memorial Sloan-Kettering Cancer Center	39.4%
330354	Roswell Park Cancer Institute	13.6%
360242	James Cancer Hospital & Solove Research Institute	12.7%
390196	Fox Chase Cancer Center	10.4%
450076	M.D. Anderson Cancer Center	41.9%
500138	Seattle Cancer Care Alliance	44.8%

Proposed Measure Changes within the Hospital OQR Program
CMS does not propose any changes to any measure additions for the Hospital OCR Program.

Inpatient Only List
Services on the IPO list are not paid under the OPPS. Currently, the IPO list includes approximately 1,740 services. CMS annually reviews the IPO list to identify any services that should be removed from or added to the list based on the most recent data and medical evidence available using criteria specified annually in the OPPS rule. In previous years, CMS received comments from stakeholders who believe the IPO list should be eliminated and deference given to the clinical judgment of physicians for selecting where to perform a service. In this proposed rule, CMS proposes to eliminate the IPO list over a transitional period beginning in 2021 and ending in 2024. For 2021, CMS proposes to remove musculoskeletal services from the IPO list.

Supervision of Outpatient Therapeutic Services
In the CY 2020 HOPPS final rule, CMS finalized a policy to change the generally applicable minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and critical access hospitals (CAHs). For those services that maintained direct supervision, CMS changed the supervision level to general during the COVID-19 PHE in an interim final rule. This policy was adopted to provide flexibility for Medicare beneficiaries to be able to receive medically necessary services without jeopardizing their health or the health ofproviders , while minimizing the overall risk to public health. CMS believes that these policies are appropriate outside of the PHE and should apply permanently. Therefore, CMS proposes to change the required supervision level for Non-Surgical Extended Duration Therapeutic Services (NSEDTS). These non-surgical services have a significant monitoring component that can extend for a lengthy period of time. NSEDTS typically have a low risk of complications after the assessment at the beginning of the service. The minimum default supervision level for NSEDTS is direct supervision during the initiation of the service followed by general supervision at the discretion of the supervising physician or the appropriate non-physician practitioner during the monitoring period. CMS believes changing the level of supervision for NSEDTS permanently to general for the entirety of the service would be beneficial to patients and hospitals. The requirement for general supervision does not preclude these hospitals from providing direct supervision for any part of the service when appropriate to do so.

The ACR's HOPPS Committee and staff will review these changes and will draft comments during the 60-day comment period. Those comments are due to CMS by October 5th, 2020.