

CMS Release CY 2022 HOPPS Propose Rule

On July 19, 2021, the Centers Medicare and Medicaid Services (CMS) released the calendar year (CY) [2022 Hospital Outpatient Prospective Payment System](#) (HOPPS) proposed rule. This rule provides for a 60-day comment period ending on September 17, 2021. The final rule with comment period will be issued in early November. The finalized changes will appear in the final rule and are effective January 1, 2022.

CMS proposes to increase the conversion factor by 2.3 percent bringing it up to \$ 84.457 for CY 2022. CMS proposes to continue to implement the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements by applying a reporting factor of 0.9805 to the OPSS payments and copayments for all applicable services. The reduced conversion factor for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements is proposed to be \$ 82.81.

In the CY 2022 HOPPS Proposed Rule, CMS proposes to place 71271 (Low Dose CT for Lung Cancer Screening) in the lowest Imaging without Contrast APC (5521), with payment rate of \$83.01. In addition, CMS proposes to place G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment rate of \$76.73. The ACR has raised concerns about the inadequate payments for CT lung screening based on flawed hospital data.

CMS has proposed no structural changes to the seven imaging APCs.

CY 2022 HOPPS Proposed Imaging APCs

APC	Group Title	CY 2021 Payment Rate	CY 2022 Proposed Payment Rate
5521	Level 1 Imaging without Contrast	\$80.90	\$83.01
5522	Level 2 Imaging without Contrast	\$108.97	\$111.73
5523	Level 3 Imaging without Contrast	\$230.13	\$236.14
5524	Level 4 Imaging without Contrast	\$482.89	\$495.76
5571	Level 1 Imaging with Contrast	\$178.55	\$183.30
5572	Level 2 Imaging with Contrast	\$368.12	\$377.80
5573	Level 3 Imaging with Contrast	\$715.18	\$733.76

CMS did not propose any additional Comprehensive APCs (C-APCs) for CY 2022. Table 1 in the proposed rule lists the proposed C-APCs for CY 2022, all of which were established in past rules.

For 2022, CMS proposes to cease the elimination of the Inpatient Only List (IPO) list. Additionally, after clinical review of the services removed from the IPO list in CY 2021 CMS proposed to add the 298 services removed from the IPO list in CY 2021 back to the IPO list beginning in CY 2022. CMS proposes

to codify in regulation the five longstanding criteria used to determine whether a procedure or service should be removed from the IPO list. In addition, CMS is seeking comments on several policy modifications including whether CMS should maintain the longer-term objective of eliminating the IPO list or maintain the IPO list but continue to systematically scale the list back so that inpatient only designations are consistent with current standards of practice.

On January 1, 2021, the Hospital Price Transparency final rule took effect. In this proposed rule, CMS is proposing several modifications designed to increase compliance and reduce hospital burden beginning January 1, 2022, including the following:

- CMS proposes to set a minimum CMP of \$300/day that would apply to smaller hospitals with a bed count of 30 or fewer and apply a penalty of \$10/bed/day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of \$5,500.
- CMS proposes to modify the hospital price transparency regulation's deeming policy to include state forensic hospitals as having met requirements, so long as such facilities provide treatment exclusively to individuals who are in the custody of penal authorities and do not offer services to the general public.
- CMS proposes to update the list of activities that present barriers to access to the machine-readable file, specifically to require that the machine-readable file is accessible to automated searches and direct downloads.

In response to the COVID-19 pandemic, CMS undertook emergency rulemaking to implement several flexibilities to address the pandemic. While many of these flexibilities will expire at the conclusion of the PHE, CMS is seeking comment on whether there are certain policies that should be made permanent. Also, CMS is seeking comment on 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 code and payment for COVID-19 specimen collection.

Radiation Oncology Model

CMS proposes significant changes to the Radiation Oncology Model. Under the Radiation Oncology (RO) Model, Medicare would pay participating providers and suppliers a site-neutral, episode-based payment for specified professional and technical radiation therapy services furnished during a 90-day episode to Medicare fee-for service (FFS) beneficiaries diagnosed with certain cancer types. The RO Model will include 30 percent of all eligible RO episodes. The Consolidated Appropriations Act (CAA), 2021, included a provision that prohibits implementation of the RO Model before January 1, 2022. In the HOPPS Proposed Rule, CMS proposes provisions related to the additional delayed implementation of the RO Model due to the CAA, 2021, as well as modifications to certain RO Model policies not related to the delay.

Performance Period

CMS is proposing to modify the RO Model performance period to January 1, 2022 through December 31, 2026. CMS is also proposing that each performance period will be a 12-month period, unless the initial model performance period starts mid-year, in which case performance year (PY)1 will begin on that date and end on December 31 of that year.

CMS is proposing to add a definition for “baseline period” specifying which episodes are used in the pricing methodology. The baseline period would be January 1, 2017 through December 31, 2019, unless the RO Model is prohibited by law from starting in 2022.

Participant Exclusions

CMS is proposing to exclude from the RO Model only the HOPDs that are participating in the Pennsylvania Rural Health Model (PARHM), rather than excluding both HOPDs in the PARHM and those that are eligible to participate in the PARHM.

CMS is also proposing that the HOPD of any participating hospital in the Community Transformation Track of the Community Health Access and Rural Transformation (CHART) Model is excluded from the RO Model.

CMS is proposing that an entity would not be eligible for low-volume opt-out if its legacy TIN or legacy CCN was used to bill Medicare for 20 or more episodes, or RO episodes, as applicable, of RT services in the two years prior to the applicable PY.

Changes to RO Model Episodes

CMS is proposing to amend the criteria to include cancer types in the RO Model, which as a result would remove liver cancer from the list of cancer types included.

CMS is proposing to remove brachytherapy as an included modality in the RO Model.

CMS is seeking comments on whether and how the Agency may include Intraoperative Radiotherapy (IORT) in the model pricing methodology in future years.

Pricing Methodology

CMS proposes to lower the discount factor for PC from 3.75% to 3.5%, and for TC from 4.75% to 4.5%.

CMS is proposing that RO participants submit quality measure data starting in PY 1, and that starting in PY 1, a 2% quality withhold for the PC would be applied to the applicable trended national base rates after the case mix and historical experience adjustments.

CMS proposes to modify the geography adjustment to align with the proposed model performance period so that the final year of the baseline period would be used to calculate the implied RVU shares.

CMS is proposing that Professional participants and Dual participants submit clinical data elements (CDEs) starting in PY 1.

Advanced APM/MIPS APM

CMS proposes to define “Track One” of the RO Model to mean an Advanced APM or MIPS APM track for dual participants and professional participants that use CEHRT. CMS proposes to define “Track Two” of the RO Model to mean an APM for Dual participants and Professional participants who do not meet the RO Model requirements to participate as an advanced APM or MIPS APM; and Technical participants.

CMS proposes that if Technical participants in freestanding radiation therapy centers start providing PC at any point during the model performance period, they must notify CMS within 30 days.

CMS is proposing that the CEHRT requirement would begin in PY1 of the proposed model performance period and that RO Model participants must certify their use of CEHRT at the start of PY1.

CMS is proposing that in cases where a beneficiary switches from traditional FFS to Medicare Advantage during an episode before treatment is complete, the Agency would consider this an incomplete episode and RT services will be paid FFS as opposed to the bundled payment.

Extreme and Uncontrollable Circumstances

CMS proposes to adopt an extreme and uncontrollable circumstances policy for the RO Model which would allow CMS to revise the model performance period; grant certain exceptions for RO Model requirements to ensure the delivery of safe and efficient care; and revise the RO Model's payment methodology.

The ACR is reviewing the proposed rule and will release a detailed summary in the coming weeks. If you have any questions, please email Christina Berry at cberry@acr.org.