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2022 Hospital Outpatient Prospective Payment System – Proposed Rule Summary

On Monday, July 19, 2021, the Centers for Medicare & Medicaid Services (CMS) released the 2022 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule, which includes modest payment increases for radiation therapy services effective January 1, 2022. Comments on the proposed rule are due September 17, 2021.

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.

Also released on July 19, 2021 was the Radiation Oncology (RO) Model proposed regulations. ASTRO's summary of that proposal also are included in a separate document.

Proposed Conversion Factor Update

CMS proposes increasing the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.3%. This increase factor is based on the hospital inpatient market basket percentage increase of 2.5% for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus a 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 2022 will be approximately $82.704 billion, an increase of $10.757 billion compared to 2021 HOPPS payments.

Ambulatory Payment Classifications (APC)

CMS is proposing to make modest changes to the payment rates of traditional radiation oncology APCs in the 2022 HOPPS proposed rule. Below is a list of radiation oncology APCs with their proposed 2022 payment rates:

Radiation Oncology - Ambulatory Payment Classification Proposed 2022 Payment Rates				
APC	Descriptor	2021 Rate	2022 Proposed Rate	% Change
5611	Level 1 Therapeutic Radiation Treatment Preparation	$126.87	$130.19	2.62%
5612	Level 2 Therapeutic Radiation Treatment Preparation	$338.68	$347.44	2.59%
5613	Level 3 Therapeutic Radiation Treatment Preparation	$1,262.18	$1,296.25	2.70%
5621	Level 1 Radiation Therapy	$120.54	$123.77	2.68%

5622	Level 2 Radiation Therapy	$241.68	$248.00	2.61%
5623	Level 3 Radiation Therapy	$542.55	$556.78	2.62%
5624	Level 4 Radiation Therapy - HDR Brachytherapy	$708.46	$727.71	2.72%
5625	Level 5 Radiation Therapy - Proton Therapy	$1,297.92	$1,327.15	2.25%
5626	Level 6 Radiation Therapy - SBRT	$1,733.74	$1,779.34	2.63%

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 2022, CMS does not seek to further expand the Comprehensive Ambulatory Payment Classification (C-APC) methodology as it is not proposing to add any new C-APCs. This will leave the number of C-APCs at 69. Below is a comparison table of the 2021 payment rates and proposed 2022 payment rates for the radiation oncology services in several key C-APCs:

C-APC 5627 Level 7 Radiation Therapy				
CPT Code	Descriptor	2021 Rate	2022 Proposed Rate	% Change
77371	SRS Multisource	$7,772.76	$7,977.39	2.63%
77372	SRS Linear Based	$7,772.76	$7,977.39	2.63%
77424	IORT delivery by x-ray	$7,772.76	$7,977.39	2.63%
77425	IORT delivery by electrons	$7,772.76	$7,977.39	2.63%
C-APC 5092 Level 2 Breast/Lymphatic Surgery and Related Procedures				
19298	Place breast rad tube/caths	$5,533.94	$5,678.67	2.62%
C-APC 5093 Level 3 Breast/Lymphatic Surgery and Related Procedures				
19296	Place po breast cath for rad	$8,920.04	$9,149.07	2.57%
C-APC 5113 Level 3 Musculoskeletal Procedures				
20555	Place ndl musc/tis for rt	$2,830.40	$2,906.75	2.70%
C-APC 5165 Level 5 ENT Procedures				
41019	Place needles h&n for rt	$5,086.05	$5,218.17	2.60%
C-APC 5302 Level 2 Upper GI Procedures				
43241	Egd tube/cath insertion	$1,625.02	$1,666.59	2.56%
C-APC 5375 Level 5 Urology and Related Services				
55875	Transperi needle place pros	$4,413.90	$4,527.23	2.57%

C-APC 5415 Level 5 Gynecologic Procedures				
55920	Place needles pelvic for rt	$4,409.54	$4,525.49	2.63%
57155	Insert uteri tandem/ovoids	$4,409.54	$4,525.49	2.63%
58346	Insert heyman uteri capsule	$4,409.54	$4,525.49	2.63%

Although 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 2019 claims data, CMS proposes to continue the two-times rule exception for APC 5612 *Level 2 Therapeutic Radiation Treatment Preparation* and for APC 5627 *Level 7 Radiation Therapy.*

Brachytherapy Sources

In the 2022 HOPPS proposed rule, CMS is proposing 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 2019 claims data to set the proposed 2022 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 2022. C2636 *Brachytherapy linear source, non-stranded, palladium-103, per 1 mm,* also is exempt from the geometric mean cost method and will be paid at the rate of $31.40 per mm.

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 2022, the proposed rates are $38.38 for C2698 and $34.99 for C2699. This is a 2.62% change in payment for C2698 and an 11.43% change for C2699 from the 2021

rates.

CMS is also proposing to establish a Low Volume APC policy for brachytherapy APCs (also for New Technology APCs and clinical APCs—it would be universal). For those APCs with fewer than 100 single claims that can be used for rate setting purposes in the existing claims year, they are proposing to use up to four years of claims data to establish a payment rate for each item or service as they currently do for low volume services assigned to New Technology APCs. Further, they propose to calculate the cost based on the greatest of the arithmetic mean cost, median cost, or geometric mean cost. They are proposing to designate 5 brachytherapy APCs as Low Volume APCs for CY 2022 (See Table 36 below). If this Low Volume APC policy is adopted, CMS would end the separate New Technology APC low volume policy discussed below since it would be universal.

Table 36: Cost Statistics for Proposed Low Volume APCs for CY 2022

APC	APC Description	Geometric Cost without Low Volume APC Designation	Proposed Median Cost	Proposed Arithmetic Mean Cost	Proposed Geometric Mean Cost	CY 2022 Proposed APC Cost
2632	Iodine I-125 sodium iodide	$26.04	$30.24	$38.52	$34.16	$38.52
2635	Brachytx, non-str, HA, P-103	$44.37	$34.04	$43.53	$36.72	$43.53
2636	Brachy linear, nonstr, P-103	$30.59	$24.78	$50.16	$36.43	$50.16
2645	Brachytx, non-str, Gold-198	$280.90	$61.85	$588.31	$131.86	$588.31
2647	Brachytx, NS, NonHDRIr-192	$275.13	$145.36	$196.38	$94.24	$196.38

Finally, CMS continues to invite recommendations for new codes to describe new brachytherapy sources.

New HCPCS Codes Effective July 1, 2021

For the July 2021 update to HCPCS codes, 55 new codes were established and made effective July 1, 2021. Through the July 2021 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, 2021 (the only one relevant to radiation oncology is listed in Table 6 below).

Table 6: New HCPCS Codes Effective July 1, 2021

CY 2021 HCPCS Code	CY 2021 Long Descriptor	Proposed CY 2022 Comment Indicator	Proposed CY 2022 Status Indicator	Proposed CY 2022 APC
0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging	NP (new code for next calendar year or existing code with substantial revision)	J1	5374

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. They consider 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 their 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 2022, 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 they are using the same claims as they did for CY 2021, they found the same values for the geometric mean cost, arithmetic mean cost, and the median cost for CY 2022. 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 2022. 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

CY 2022 HCPCS Code	Long Descriptor	Proposed CY 2022 OPPS SI	Proposed CY 2022 OPPS APC	Proposed CY 2022 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

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. CMS proposes to continue to provide 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. However, the 21st Century Cures Act requires that this weighted average PCR be reduced by 1.0%. Based on the data and the required 1.0% reduction, CMS is proposing that a target PCR of 0.89 would be used to determine the CY 2022 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 0.89 for each cancer hospital.

Table 4 shows the estimated percentage increase in OPPS payments to each cancer hospital for CY 2022, due to the cancer hospital payment adjustment policy.

Table 4: Estimated CY 2022 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 2022 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	31.3%
050660	USC Norris Cancer Hospital	9.9%
100079	Sylvester Comprehensive Cancer Center	16.5%
100271	H. Lee Moffitt Cancer Center & Research Institute	20.8%
220162	Dana-Farber Cancer Institute	34.3%
330154	Memorial Sloan-Kettering Cancer Center	38.1%
330354	Roswell Park Cancer Institute	14.0%
360242	James Cancer Hospital & Solove Research Institute	16.4%
390196	Fox Chase Cancer Center	11.2%
450076	M.D. Anderson Cancer Center	51.4%

500138	Seattle Cancer Care Alliance	46.5%

Health Equity
Similar to proposals put forth in the 2022 Inpatient Prospective Payment System and Medicare Physician Fee Schedule proposed rules, CMS is seeking input on ways to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable. This includes soliciting comments on potential collection of data and analysis and reporting of quality measure results by a variety of demographic data points including, but not limited to, race, Medicare/Medicaid dual eligibility status, disability status, LGBTQ+, and socioeconomic status.

Hospital Price Transparency Fines
CMS is proposing to amend several hospital price transparency policies in order to encourage compliance. The proposals include to: (1) increase the amount of the penalties for noncompliance through the use of a proposed scaling factor based on hospital bed count; (2) deem state forensic hospitals that meet certain requirements to be in compliance with the requirements of 45 CFR part 180; and (3) prohibit certain conduct that the Agency has concluded are barriers to accessing the standard charge information.

In addition, they are clarifying 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. They also seek comment on a variety of issues that they may consider in future rulemaking, including improving standardization of the data disclosed by hospitals.

Additional information about the 2022 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/2021-15496.pdf

The addenda relating to the HOPPS proposed rule are available at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

A fact sheet on this proposed rule is available at:
https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center