

## **2020 Hospital Outpatient Prospective Payment System Final Rule Summary**

On November 2, 2019, the Centers for Medicare & Medicaid Services (CMS) released the 2020 Hospital Outpatient Prospective Payment System (HOPPS) [final rule](#), which included modest payment increases for several radiation oncology services, as well as changes to the supervision requirements associated with the delivery of hospital outpatient therapeutic services, including radiation therapy.

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 HOPPS 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.

### **Update**

In accordance with Medicare law, CMS is increasing the payment rates under the HOPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.7 percent. This increase factor is based on the hospital inpatient market basket percentage increase of 3.2 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus a 0.5 percentage point adjustment for multifactor productivity (MFP). 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 2020 will be approximately \$79 billion, an increase of \$6.3 billion compared to 2019 HOPPS payments.

### **Ambulatory Payment Classifications (APC)**

CMS finalized modest changes to the payment rates of traditional radiation oncology APCs in the 2020 HOPPS final rule. Below is a list of radiation oncology APCs with final 2020 payment rates:

Radiation Oncology - Ambulatory Payment Classification Final 2020 Payment Rates				
APC	Descriptor	2019 Rate	2020 Final Rate	% Change
5611	Level 1 Therapeutic Radiation Treatment Preparation	\$ 124	\$ 127	2%
5612	Level 2 Therapeutic Radiation Treatment Preparation	\$ 322	\$ 335	4%
5613	Level 3 Therapeutic Radiation Treatment Preparation	\$ 1,192	\$ 1,245	4%
5621	Level 1 Radiation Therapy	\$ 117	\$ 123	5%
5622	Level 2 Radiation Therapy	\$ 224	\$ 236	5%
5623	Level 3 Radiation Therapy	\$ 520	\$ 539	4%
5624	Level 4 Radiation Therapy - HDR Brachytherapy	\$ 705	\$ 740	5%
5625	Level 5 Radiation Therapy - Proton Therapy	\$ 1,079	\$ 1,247	16%
5626	Level 6 Radiation Therapy - SBRT	\$ 1,691	\$ 1,768	5%

### **Comprehensive Ambulatory Payment Classifications (C-APCs)**

CMS continues to expand the Comprehensive Ambulatory Payment Classification (C-APC) methodology by finalizing two new C-APCs. The new C-APCs include C-APC 5182 *Level 2 Vascular Procedures* and C-APC 5461 *Level 1 Neurostimulator and Related Procedures*. The addition of these new C-APCs increases the total number of C-APCs to 67. 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.

ASTRO recognizes that CMS is committed to the C-APC methodology, and we support CMS policies that promote efficiency and the provision of high-quality care. However, the methodology used to create C-APCs lacks the appropriate charge capture mechanisms; as it is currently applied, it grossly undervalues cancer treatments, particularly brachytherapy.

In the 2020 HOPPS final rule, CMS reassigned CPT codes 57155 *Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy* and 58346 *Insertion of Heyman capsules for clinical brachytherapy* from C-APC 5414 *Level 4 Gynecologic Procedures* to C-APC 5415 *Level 5 Gynecologic Procedures*. Although this decision increases the reimbursement rate of both codes from \$2,361 in 2019 to \$4,271 in 2020, ASTRO is concerned that this increase still does not adequately account for the cost of treatment delivery. In proposed rule comments, ASTRO advocated for a reassignment to C-APC 5416 *Level 6 Gynecologic Procedures*, which is reimbursed at \$6,703, representing a more accurate reimbursement rate for treatment delivery.

Below is a comparison table of the 2019 payment rates and final 2020 payment rates for the radiation oncology services in several key C-APCs:

<b>C-APC 5627 Level 7 Radiation Therapy</b>				
CPT Code	Descriptor	2019 Rate	2020 Final Rate	% Change
77371	SRS Multisource	\$ 7,644	\$7,942	4%
77372	SRS Linear Based	\$ 7,644	\$7,942	4%
77424	IORT delivery by x-ray	\$ 7,644	\$7,942	4%
77425	IORT delivery by electrons	\$ 7,644	\$7,942	4%
<b>C-APC 5092 Level 2 Breast/Lymphatic Survery and Related Procedures</b>				
19298	Place breast rad tube/caths	\$ 4,915	\$5,237	7%
<b>C-APC 5093 Level 3 Breast/Lymphatic Survery and Related Procedures</b>				
19296	Place po breast cath for rad	\$ 7,449	\$8,135	9%
<b>C-APC 5113 Level 3 Musculoskeletal Procedures</b>				
20555	Place ndl musc/tis for rt	\$ 2,623	\$2,737	4%
<b>C-APC 5165 Level 5 ENT Procedures</b>				
41019	Place needles h&n for rt	\$ 4,424	\$4,850	10%
<b>C-APC 5302 Level 2 Upper GI Procedures</b>				
43241	Egd tube/cath insertion	\$ 1,483	\$1,557	5%
<b>C-APC 5375 Level 5 Urology and Related Services</b>				
55875	Transperi needle place pros	\$ 4,021	\$4,231	5%
<b>C-APC 5415 Level 5 Gynecologic Procedures</b>				
55920	Place needles pelvic for rt	\$ 4,126	\$4,271	4%
<b>57155</b>	<b>Insert uteri tandem/ovoids</b>	<b>\$ 2,361</b>	<b>\$4,271</b>	<b>81%</b>
<b>58346</b>	<b>Insert heyman uteri capsule</b>	<b>\$ 2,361</b>	<b>\$4,271</b>	<b>81%</b>

In the 2020 HOPPS final rule, CMS recognizes ASTRO's concerns regarding the C-APC methodology; however, the Agency remains committed to the methodology and does not intend to modify the methodology for radiation oncology services. ASTRO is disappointed by this and will continue to educate CMS on the impact the C-APC methodology has on radiation oncology services, particularly brachytherapy.

### **General Supervision Requirements Expanded to All Hospital Outpatient Therapeutic Services**

In the 2020 HOPPS proposed rule, CMS proposed expansion of the general supervision requirement to all hospital outpatient therapeutic services. According to the Agency, the enforcement instructions and legislative actions that have been in place since 2010, establish a two-tiered system in which direct supervision is required for most hospital therapeutic services, but allow an exception for services at critical access hospitals (CAHs) and at hospitals with 100 or fewer beds to be delivered under general supervision. Additionally, CMS believes that the direct supervision requirement for hospital outpatient therapeutic services places an additional burden on providers that reduces their flexibility to provide medical care.

In the 2020 HOPPS final rule, CMS finalized its decision to change the minimum required level of supervision from direct supervision to general supervision for all hospital outpatient therapeutic services provided by all hospitals and CAHs. This change does not impact

freestanding radiation oncology clinics. The final rule states that general supervision means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. According to the Agency, this establishes a standard minimum level of supervision for each hospital outpatient service furnished incident to a physician's service. CMS further asserts that "providers have the flexibility to establish what they believe is the appropriate level of physician supervision for these procedures, which may well be higher than the requirements for general supervision."

ASTRO expressed concern about this proposal and its application to radiation oncology services in its proposed rule comments, recommending that the current supervision policy should be retained for radiation oncology to protect patients and ensure the continued delivery of safe and high-quality radiation therapy services. ASTRO is very concerned about this decision and how it will impact patient care.

### **Two-Times Rule Exception**

CMS finalized continuation of the two-times rule exception for APC 5612 *Level 2 Therapeutic Radiation Treatment Preparation*. 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 concentration
- Frequency of service (volume)
- Opportunity for upcoding and code fragments

### **Brachytherapy Sources**

In the 2020 HOPPS final rule, CMS finalized its proposal to use costs derived from 2018 claims data to set the 2020 payment rates for brachytherapy sources. The payment rates are based on the geometric mean costs for each source, which is consistent with the methodology used for other services under HOPPS. The Agency did not finalize any additional changes to payment policies for brachytherapy sources.

### **Stranded/Non-Stranded**

CMS finalized payment 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 2020, the proposed rates are \$35.96 for C2698 and \$36.45 for C2699. This is a 1 percent decrease in payment for C2698 from the 2019 rate of \$36.40 and a 34 percent increase for C2699 from the 2019 rate of \$27.12.

### **C2645 Brachytherapy planar, p-103**

In 2019, the Agency used one claim with one unit of C2645 to maintain a \$4.69 per mm rate, which has been in place since 2017. For 2020, the Agency proposed a rate of \$1.02 per mm

based on two claims with over 9,000 units of C2645, a 78 percent decline in reimbursement.

After consideration of public comment, the Agency did not finalize the proposed rate for C2645. Instead, CMS is assigning the brachytherapy source described by HCPCS code C2645 a payment rate of \$4.69 for 2020, aligning with the 2019 rate. The Agency determined that given the limited number of claims for HCPCS code C2645 for both 2019 and previous calendar years, the proposed 2020 payment rate did not adequately represent the costs associated with C2645.

### **Proposed Drugs and Biologicals with New or Continuing Pass-Through Payment Status**

For purposes of pass-through payment, CMS considers radiopharmaceuticals to be drugs under the HOPPS system. CMS finalized continuation of pass-through payment status for HCPCS code A9513 *Lutetium lu 177, dotatate, therapeutic, 1 millicurie*, under APC 9067 at a rate of \$259.17. Additionally, CMS finalized a new pass-through payment status for HCPCS code C9408 *Iodine i-131, iobenguane, therapeutic, 1 millicurie*. The new pass through payment for C9408 is based on the Average Sales Price (ASP) payment methodology, which is finalized at ASP + 6 percent. If ASP data are not available, the Agency will use Wholesale Acquisition Cost (WAC) + 3 percent in the upcoming calendar year. If WAC information is not available, CMS will provide pass-through payment at 95 percent of the most recent Average Wholesale Price.

### **Proposal to Fast-Track Device Pass-Through Payment for Transformative New Devices**

CMS finalized to grant fast-track device pass-through payment under HOPPS for devices approved under the Federal Drug Administration's (FDA) Breakthrough Devices Program and receive FDA marketing authorization. These devices will be considered new and would not be required to meet the requirement that it substantially improves, relative to the existing technologies, the diagnosis or treatment of Medicare beneficiaries. This new approach would apply to pass-through payment applications received on or after January 1, 2020 for application in 2021.

### **Evaluation of Substantial Clinical Improvement Criterion for Transitional Pass-Through Payments for Devices**

In the 2020 HOPPS proposed rule, as well as the 2020 Inpatient Prospective Payment System/Long Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) proposed rule, CMS sought comment on the "substantial clinical improvement" criterion for evaluating applications for the HOPPS transitional pass-through payment for devices.

Existing regulations provide that a new technology is an appropriate candidate for additional payment when it represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries. For example, a new technology represents a substantial clinical improvement when it reduces mortality, decreases the number of hospitalizations or physician visits, or reduces recovery time compared to the technologies previously available.

In the 2020 HOPPS final rule, CMS refers readers to the FY 2020 IPPS/LTCH PPS final rule for complete details on those potential revisions, which include recognition that additional clarity regarding the requirements associated with the "substantial clinical improvement" criterion will

help the public better understand how CMS evaluates new technology applications for add-on payments and will provide greater predictability about which applications will meet the criterion. While CMS did not finalize any changes to the criterion for 2020, the Agency will use comments to inform future rule making.

Additional information about the 2020 HOPPS final rule can be found at the following links:

A display copy of the final rule can be found at:

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24138.pdf>

A fact sheet on this final rule is available at:

<https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0>

The Addenda relating to the HOPPS final rule are available at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>