ASTRO
TARGETING CANCER CARE

251 18th St. South, 8th Floor
Arlington, VA 22202

Main: 703.502.1550 · Fax: 703.502.7852
www.astro.org · www.rtanswers.org

2020 Hospital Outpatient Prospective Payment System
Proposed Rule Summary

On July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) released the 2020 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule, including some modest payment increases for radiation therapy codes. Comments on the proposed rule are due September 27, 2019.

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.

Update

CMS proposes increasing the payment rates under the OPPS 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 billion compared to 2019 HOPPS payments.

Ambulatory Payment Classifications (APC)

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

Radiation Oncology - Ambulatory Payment Classification Proposed 2020 Payment Rates				
APC	Descriptor	2019 Rate	2020 Proposed Rate	% Change
5611	Level 1 Therapeutic Radiation Treatment Preparati	$ 124	$ 128	4%
5612	Level 2 Therapeutic Radiation Treatment Preparation	$ 322	$ 339	5%
5613	Level 3 Therapeutic Radiation Treatment Preparati	$ 1,192	$ 1,261	6%
5621	Level 1 Radiation Therapy	$ 117	$ 124	6%
5622	Level 2 Radiation Therapy	$ 224	$ 240	7%
5623	Level 3 Radiation Therapy	$ 520	$ 546	5%
5624	Level 4 Radiation Therapy - HDR Brachytherapy	$ 705	$ 754	7%
5625	Level 5 Radiation Therapy - Proton Therapy	$ 1,079	$ 1,203	11%
5626	Level 6 Radiation Therapy - SBRT	$ 1,691	$ 1,791	6%

Comprehensive Ambulatory Payment Classifications (C-APCs)

CMS continues to expand the Comprehensive Ambulatory Payment Classification (C-APC) methodology by proposing two new C-APCs. The proposed 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. 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.

In the 2020 HOPPS proposed rule, CMS does not propose to make any modifications to existing radiation oncology C-APCs. Below is a comparison table of the 2019 payment rates and proposed 2020 payment rates for the radiation oncology services in several key C-APCs:

C-APC 5627 Level 7 Radiation Therapy				
CPT Code	Descriptor	2019 Rate	2020 Propsed Rate	% Change
77371	SRS Multisource	$ 7,644	$8,037	5%
77372	SRS Linear Based	$ 7,644	$8,037	5%
77424	IORT delivery by x-ray	$ 7,644	$8,037	5%
77425	IORT delivery by electrons	$ 7,644	$8,037	5%
C-APC 5092 Level 2 Breast/Lymphatic Survery and Related Procedures				
19298	Place breast rad tube/caths	$ 4,915	$5,302	8%
C-APC 5093 Level 3 Breast/Lymphatic Survery and Related Procedures				
19296	Place po breast cath for rad	$ 7,449	$8,173	10%
C-APC 5113 Level 3 Musculoskeletal Procedures				
20555	Place ndl musc/tis for rt	$ 2,623	$2,782	6%
C-APC 5165 Level 5 ENT Procedures				
41019	Place needles h&n for rt	$ 4,424	$4,913	11%
C-APC 5302 Level 2 Upper GI Procedures				
43241	Egd tube/cath insertion	$ 1,483	$1,571	6%
C-APC 5375 Level 5 Urology and Related Services				
55875	Transperi needle place pros	$ 4,021	$4,286	7%
C-APC 5414 Level 4 Gynecologic Procedures				
57155	Insert uteri tandem/ovoids	$ 2,361	$2,565	9%
58346	Insert heyman uteri capsule	$ 2,361	$2,565	9%
C-APC 5415 Level 5 Gynecologic Procedures				
55920	Place needles pelvic for rt	$ 4,126	$ 4,426	7%

Two-Times Rule Exception

CMS proposes to continue the two-times 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
- Code fragmentation

Brachytherapy Sources

In the 2020 HOPPS proposed rule, CMS is proposing to use costs derived from 2018 claims data to set the 2020 payment rates for brachytherapy sources. The payment rates are proposed to be

based on the geometric mean costs for each source, which is consistent with the methodology used for other services under HOPPS. The Agency is not proposing any changes to payment policies for brachytherapy sources.

Stranded/Non-Stranded
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 nonstranded 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*
For 2020, CMS proposes to continue using indicator "U" (Brachytherapy Sources, Paid under HOPPS; separate APC payment) for HCPCS code C2645. 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, they Agency is proposing a rate of $1.02 per mm based on two claims with over 9,000 units of C2645. This is a 78 percent decline in reimbursement.

New Brachytherapy Source Codes
CMS continues to invite recommendations for new codes to describe new brachytherapy sources.

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

In the 2020 HOPPS proposed rule, CMS is proposing to continue pass-through payment status *Lutetium lu 177, dotatate, therapeutic, 1 millicurie*, as well establishing new pass-through payment status for *Iodine i-131, iobenguane, therapeutic, 1 millicurie*. For purposes of pass-through payment, CMS considers radiopharmaceuticals to be drugs under the HOPPS system. Therefore, the Agency proposes to apply the Average Sales Price (ASP) payment methodology to determine the pass-through payment rate, which is proposed at ASP + 6 percent. If ASP data are not available, the Agency proposes to use Wholesale Acquisition Cost (WAC) + 3 percent procedure in the upcoming calendar year. If WAC information is not available, CMS proposes to 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 is proposing 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 would 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 FY 2021.

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

CMS is seeking comment on the "substantial clinical improvement" criterion for evaluating applications for the OPPS 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.

The Agency recognizes 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. The request for comments is intended to inform future rule making but may result in changes applied to the 2020 HOPPS rules.

Supervision Policy for Rural Practices

In the 2009 HOPPS final rule, CMS clarified that direct supervision is required for hospital outpatient therapeutic services covered and paid by Medicare in hospitals as well as in provider-based departments of hospitals. In the 2010 HOPPS final rule, CMS clarified that this standard applies to Critical Access Hospitals (CAHs) and small rural hospitals with fewer than 100 beds. In response to concerns expressed by the hospital community, in particular CAHs and small rural hospitals who indicated that they would have difficulty meeting this standard, CMS instructed all Medicare contractors not to evaluate or enforce the supervision requirements for therapeutic services provided to outpatients in CAHs and rural hospitals from January 1, 2010 through December 31, 2010. This non-enforcement policy was extended in 2011, 2012, 2013, and most recently in 2018 with an expiration of December 31, 2019.

In the 2020 HOPPS proposed rule, CMS is proposing 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 proposal would ensure a standard minimum level of supervision for each hospital outpatient service furnished incident to a physician's service.

CMS establishes that the agency is not aware of any supervision-related complaints from beneficiaries or providers regarding the quality of care for services furnished since 2010. According to the Agency, the enforcement instructions and legislative actions that have been in place since 2010 created a two-tiered system of physician supervision requirements for hospital outpatient therapeutic services for providers in the Medicare program, "with direct supervision required for most hospital outpatient therapeutic services in most hospital providers, but only general supervision required for most hospital outpatient therapeutic services in CAHs and small rural hospitals with fewer than 100 beds." 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. The Agency is seeking feedback regarding this proposed modification to hospital-based supervision policies.

Comment Solicitation on Cost Reporting, Maintenance of Hospital Chargemasters, and Related Medicare Payment Issues

Medicare-certified institutional providers are required to submit an annual cost report to CMS which is used to set prospective payment rates for institutions. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center, Medicare settlement data, and financial statement data. CMS is seeking comments on the continued value of chargemaster charges in setting hospital payment. The Agency is also interested in learning about the costs associated with maintaining the chargemaster for purposes of Medicare cost and reporting, as well as whether the existing Medicare cost reporting system can be streamlined and modernized.

Making Public Consumer-Friendly Standard Charges for a Set of 'Shoppable Services'

CMS is proposing to require hospitals to make public standard charge data specific "shoppable services" that hospitals provide in a form and manner that is consumer-friendly. CMS proposes to define 'shoppable service' as a service that is non-urgent, does not require immediate action or attention, and can be scheduled by a health care consumer in advance. Specifically, CMS is proposing that hospitals:

- Display payer-specific negotiated charges for at least 300 shoppable services, including 70 CMS-selected shoppable services and 230 hospital-selected shoppable services. If a hospital does not provide one or more of the 70 CMS selected shoppable services, the hospital must select additional shoppable services such that the total number of shoppable services is at least 300.
- Include charges for services that the hospital customarily provides in conjunction with the primary service that is identified by a common billing code (e.g. Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS)/Diagnosis-Related Group (DRG).
- Make sure that the charge information is displayed prominently on a publicly available webpage, clearly identifies the hospital (or hospital location), easily accessible and without barriers, and searchable.
- Update the information at least annually.

HOPPS Quality Reporting Requirements
ASTRO is developing a separate summary of the HOPPS quality reporting requirements.

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/2019-16107.pdf

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

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-P.html

A fact sheet on this proposed rule is available at:

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