Calendar Year 2020 Hospital Outpatient Prospective Payment System Proposed Rule

On July 29, 2019 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 September 27, 2019. The finalized changes will appear in the final rule in early November and are effective January 1, 2019.

Conversion Factor

CMS proposes to increase the conversion factor by 2.7 percent bringing it up to $81.398 for CY 2020. CMS determined proposed conversion factor with the use of the proposed OPD fee schedule increase factor of 2.7 percent for CY 2020, the required proposed wage index budget neutrality adjustment of approximately 0.9993, the proposed cancer hospital payment adjustment of 0.9998, and the proposed adjustment of -0.20 percentage point of projected OPPS spending for the difference in pass-through spending. This resulted in a proposed conversion factor for CY 2020 of $81.398.

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 2020 of $79.770.

Estimated Impact on Hospitals

CMS projects an estimated increase of 2.0 percent for all facilities. The proposed rule impacts vary depending on the type of facility. Impacts will differ for each hospital category based on the mix of services provided, location and other factors. In 2020, Puerto Rico will see the largest impact of 22.1 percent due to proposed changes to the wage index. The OPPS uses the same wage index as is used for the IPPS. In the FY 2020 IPPS final rule, CMS proposes to narrow the difference between the top quartile and bottom quartile wage indexes, no longer include urban to rural reclassifications in the calculation of the rural floor wage index and cap reductions to the wage index at 5 percent. As Puerto Rico has the lowest wage indexes among all OPPS hospitals, it would experience the highest overall benefit from this proposal.

PROPOSED AMBULATORY PAYMENT CLASSIFICATION GROUP POLICIES

APC Placement of New Radiology CPT Codes

In March 2019, the ACR presented CMS with recommendations for new CPT codes within APCs for CY 2020. The table below shows CMS's proposed APC placement for CY 2020. CMS agreed with ACR recommendations except for 93X00 (Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study). The ACR did not make recommendations on the APC placement of the new nuclear medicine (NM) codes because there was not time to coordinate with other NM organizations. We will also consider commenting on their proposed placements during this comment period.

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CMS Proposed APC Placement for New CPT Codes

CPT Code	Description	ACR Recommendation APC Placement	CMS Proposed APC Placement	CY 2020 Proposed Payment Rate
74X00	Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study	5571	5571	179.91
78X29	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed) single study; with concurrently acquired computed tomography transmission scan		5593	1293.33
78X31	Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fraction(s), when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan		5594	1466.16
78X32	Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fraction(s), when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan		5594	1466.16
78X33	Myocardial imaging, positron emission tomography, combined perfusion with metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed), dual radiotracer (eg, myocardial viability);		5594	1466.16

78X34	Myocardial imaging, positron emission tomography, combined perfusion with metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan		5594	1466.16
622X0	Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance	5442	5442	627.39
622X1	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance	5442	5442	627.39
788X0	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest pelvis), single day of imaging		5593	1293.33
788X1	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day of imaging, or single of imaging over 2 or more days		5593	1293.33
788X2	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of		5594	1466.16

	pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day of imaging, or single area of imaging over 2 or more days imaging			
93X00	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	5523	5522	111.04
93X01	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study	5522	5522	111.04
788X1	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day of imaging, or single of imaging over 2 or more days		5593	1293.33

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 of which would cause changed pricing for 2020. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two times rule.

Proposed CY 2020 Imaging APCs

APC	Group Title	SI	Relative Weight	CY 2019 Payment Rate	CY 2020 Proposed Payment Rate
5521	Level 1 Imaging without Contrast	S*	0.9986	$62.30	$81.28
5522	Level 2 Imaging without Contrast	S	1.3641	$112.51	$111.04
5523	Level 3 Imaging without Contrast	S	2.8413	$230.56	$231.28
5524	Level 4 Imaging without Contrast	S	5.8287	$497.49	$474.44
5571	Level 1 Imaging with Contrast	S	2.2103	$201.74	$179.91

5572	Level 2 Imaging with Contrast	S	4.5880	$385.88	$373.45
5573	Level 3 Imaging with Contrast	S	8.3904	$691.75	$682.96

*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 rulebased on the following criteria: resource homogeneity; clinical homogeneity; hospital outpatient setting utilization; frequency of service (volume); and opportunity for up-coding and code fragments.

Table 10, below, lists the 18 APCs that CMS proposes to exempt from the 2 times rule for 2020 based on claims data from January 1, 2018, through December 31, 2018 and processed on or before December 31, 2018.

Table 10. Proposed APC Exceptions to the 2 Times Rule for 2020

2020 APC	APC Title
5112	Level 2 Musculoskeletal Procedures
5161	Level 1 ENT Procedures
5181	Level 1 Vascular Procedures
5311	Level 1 Lower GI Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5612	Level 2 Therapeutic Radiation Treatment Preparation
5672	Level 2 Pathology
5691	Level 1 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5733	Level 3 Minor Procedures
5734	Level 4 Minor Procedures
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Comprehensive APCs
For CY 2020, CMS proposes to create two new comprehensive APCs (C-APCs). These proposed new C-APCs include the following: C-APC 5182 (Level 2 Vascular Procedures) and proposed C–APC 5461 (Level 1 Neurostimulator and Related Procedures). This would increase the total number of C-APCs to 67.

Changes to New-Technology APCs
CMS proposes to continue their current policy to retain services within New Technology APC groups until they obtain adequate claims data to substantiate reassignment of the service to a clinically appropriate APC.

Proposed Changes to MRgFUS
Currently, there are four CPT/HCPCS codes that describe magnetic resonance image-guided, high-intensity focused ultrasound (MRgFUS) procedures. For 2020, CMS proposes to assign 3 of the codes to standard APCs and proposes to maintain procedures described by CPT code 0398T to a New Technology APC.

Based on the 37 claims, CMS calculated a geometric mean cost of approximately $8,829, an arithmetic mean of $10,021, and a median of $11,985 for CPT code 0398T. CMS believes that the arithmetic mean is the most appropriate representative cost of the procedures described by CPT code 0398T. CMS proposes maintaining the procedure described by CPT code 0398T to APC 1575 (New Technology – Level 38 ($10,0001-$15,000)), with a proposed payment rate of $12,500.50.

Table 11. Proposed CY 2020 Status Indicator (SI), APC Assignment, And Payment Rate for the MRgFUS Procedures

CPT/ HCPCS Code	Long Descriptor	CY 2019 OPPS SI	CY 2019 OPPS APC	CY 2019 OPPS Payment Rate	Proposed CY 2020 OPPS SI	Proposed CY 2020 OPPS APC	Proposed CY 2020 OPPS Payment Rate
0071T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume less than 200 cc of tissue.	J1*	5414	$2,361.27	J1	5414	$2,564.60
0072T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume greater or equal to 200 cc of tissue.	J1	5414	$2,361.27	J1	5414	$2,564.60
0398T	Magnetic resonance image	S**	1575	$12,500.50	S	1575	$12,500.50

	guided high intensity focused 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	$10,713.88	J1	5115	$11,960.25

*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 its brachytherapy policy for 2020.

Proposed Alternative Pathway to the OPPS Device Pass-Through Substantial Clinical Improvement Criterion for Transformative New Device
Similar to the proposal in the Inpatient Prospective Payment System (IPPS) proposed rule, CMS proposes to alternative pathway to qualifying for device pass-through payment status, under which the “substantial clinical improvement” criterion would not apply. If a medical device is part of the FDA’s Breakthrough Devices Program and received marketing authorization, it will not be evaluated for substantial clinical improvement for the purposes of determining device pass-through payment status. The device will still need to meet the eligibility criteria, the other criteria for establishing device categories, and the cost criterion. CMS proposes to establish this alternative pathway for device pass-through payment applications for new medical devices received on or after January 1, 2020.

CT and MR Cost Centers
Beginning in CY 2020, 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 under-estimate 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 "direct" or the "dollar" method. These changes are the result of a study that was done by the Research Triangle Institute (RTI) back in 2007[1]. Although 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.

Table 2, below, illustrates 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 3, below, of the proposed rule provides statistical values based on the CT and MRI standard cost center CCRs using the different cost allocation methods.

Table 2. 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	-2.0%
5522	Level 2 Imaging without Contrast	5.8%
5523	Level 3 Imaging without Contrast	4.6%
5524	Level 4 Imaging without Contrast	6.8%
5571	Level 1 Imaging with Contrast	8.4%
5572	Level 2 Imaging with Contrast	8.3%
5573	Level 3 Imaging with Contrast	2.2%
8005	CT and CTA without Contrast Composite	14.2%
8006	CT and CTA with Contrast Composite	11.5%
8007	MRI and MRA without Contrast Composite	6.7%

Table 3. 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	0.0359	0.0505	0.0763	0.1027
Square Feet Only	0.0290	0.0443	0.0665	0.0927
Direct Assign	0.0511	0.0609	0.0990	0.1197
Dollar Value	0.0432	0.0583	0.0879	0.1156
Direct Assign and Dollar Value	0.0433	0.0583	0.0886	0.1155

[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

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
CMS proposes to placing G0297 (Low Dose CT for Lung Cancer Screening) in the lowest Imaging without Contrast APC (5521), with payment rate of $81.28. In addition, CMS proposes to place G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment rate of $81.06. The ACR has raised concerns about the inadequate payments for CT lung screening based on flawed hospital data in the past rules.

Policy Packaged Drugs, Biologicals, and Radiopharmaceuticals
The 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 an increased threshold payment for therapeutic radiopharmaceuticals of $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 2020, 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, displays the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals, with increases in OPPS payments for 2020 ranging from 7.1 percent to 51.9 percent.

Table 6. The Estimated Percentage Increase in OPPS Payments to Each Cancer Hospital For CY 2020, 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	36.7%
050660	USC Norris Cancer Hospital	23.0%
100079	Sylvester Comprehensive Cancer Center	23.3%
100271	H. Lee Moffitt Cancer Center & Research Institute	7.1%
220162	Dana-Farber Cancer Institute	37.6%
330154	Memorial Sloan-Kettering Cancer Center	49.7%

330354	Roswell Park Cancer Institute	22.1%
360242	James Cancer Hospital & Solove Research Institute	22.4%
390196	Fox Chase Cancer Center	10.7%
450076	M.D. Anderson Cancer Center	43.7%
500138	Seattle Cancer Care Alliance	51.9%

Proposed Measure Changes within the Hospital OQR Program
CMS does not propose any changes CMS proposes to remove one measure from the OQR Program beginning with the 2022 payment determination. CMS proposes to remove OP-33: External Beam Radiotherapy for Bone Metastases under removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

CMS does not propose any changes to other policies within the Hospital OQR Program.

Method to Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)
For CY 2020, the second year of the 2-year phase-in, CMS state it would apply the total reduction in payment that is applied if these departments (departments that bill the modifier "PO" on claims lines) are paid the site-specific PFS rate for the clinic visit service described by HCPCS code G0463.

The proposed PFS-equivalent rate for CY 2020 is 40 percent of the proposed OPPS payment (that is, 60 percent less than the proposed OPPS rate) for CY 2020. For 2021, CMS plans to adopt the remainder of the phase-in and pay 40 percent of the OPPS rate for a clinic visit furnished at excepted off campus PBD.

Supervision Level for Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals
In response to concerns expressed by stakeholders, on March 15, 2010, CMS instructed all Medicare Administrative Contractors (MACs) not to evaluate or enforce the supervision requirements for therapeutic services provided to outpatients in critical access hospitals (CAHs) from January 1 to December 31, 2010. This policy had been extended by various methods until December 31, 2019. 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. Currently, direct supervision is 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 proposes 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 CAHs. 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.

CMS will continue to have the Hospital Outpatient Payment Panel provide guidance on the appropriate supervision levels for hospital outpatient services. CMS is seeking public comment on whether specific types of services, such as chemotherapy administration or radiation therapy, should be excepted from this proposal.

Requirements for Hospitals to Make Public a List of Their Standard Charges
In the proposed rule includes proposals that would advance CMS's commitment to increasing price transparency. CMS proposes new enforcement tools including monitoring, auditing, corrective action plans, and civil monetary penalties of $300 per day to ensure compliance with the proposed new regulations.

Definition of Hospital
CMS proposes to define a "hospital" as an institution in any of the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands that is: (1) licensed as a hospital pursuant to state law or (2) approved, by the agency of such state or locality responsible for licensing hospitals, as meeting the standards to be a licensed hospital. The proposed definition of "hospital" would exclude non-hospital sites-of-care that may offer ambulatory surgical services, laboratory or imaging services, or other services that are similar or identical to the services offered by hospital outpatient departments.

Definition of "Items and Services" Provided by Hospitals
CMS proposes to define that "items and services" are all items and services, including individual items and services and packaged services, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge.

Definitions of Types of "Standard Charges"
CMS proposes to define standard charges as gross charges and payer-specific negotiated charges. A "gross charge" would be defined as the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts. CMS would define "payer-specific negotiated charge" as the charge that the hospital has negotiated with a third-party payer for an item or service.

Public Disclosure of All Hospital Standard Charges for All Items and Services
CMS proposes that standard charges be made public through a comprehensive machine-readable file that makes public all standard charge information for all hospital items and services and a consumer-friendly display of common "shoppable" services that is in a machine-readable file. The table below shows the radiology specific shoppable services.

Proposed List Shoppable Radiological Services

Radiology Service	CPT Code
CT scan, head or brain, without contrast	70450
MRI scan of brain before and after contrast	70553

X-Ray, lower back, minimum four views	72110
MRI scan of lower spinal canal	72148
CT scan, pelvis, with contrast	72193
MRI scan of leg joint	73721
CT scan of abdomen and pelvis with contrast	74177
Ultrasound of abdomen	76700
Abdominal ultrasound of pregnant uterus (greater or equal to 14 weeks 0 days) single or first fetus	76805
Ultrasound pelvis through vagina	76830
Mammography of one breast	77065
Mammography of both breasts	77066
Mammography, screening, bilateral	77067

Request for Information: Price Transparency Quality Measurement
In the CY 2019 HOPPS Proposed Rule CMS sought public comments on various issues related to making provider and supplies charges for health care services furnished in hospitals more transparent. CMS now seeks stakeholder views on related issues in two broad categories:

1. Improving availability and access to existing quality of health care information for third parties and health care entities to use when developing price transparency tools and when communicating charges for health care services.
2. Improving incentives and assessing the ability of health care providers and suppliers to communicate and share charge information with patients.

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 September 27th, 2019.