**CY 2020 HOPPS 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.

In the proposed rule includes proposals that would advance CMS's commitment to increasing price transparency. CMS proposes that hospitals make public their "standard charges" for all items and services provided by the hospital. Additionally, CMS proposes that public standard charges be made available on the internet in a machine-readable file that includes common billing or accounting codes used by hospitals and a description of the item or service to help compare standard charges between hospitals. Furthermore, hospitals must make public-payer specific negotiated charges for common shoppable service in a consumer friendly manner. 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.

CMS proposes to increase the conversion factor by 2.7 percent bringing it up to $81.398 for CY 2020. The reduced conversion factor for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements is proposed to be $79.770.

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 Although ACR has argued that the RTI study, and data which back it up, are outdated CMS is adamant to continue with fully implementing its recommendations on how to better represent cost center data in the hospital setting.

In the CY 2020 HOPPS Proposed Rule, 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 has proposed 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.

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 proposal would increase the total number of C-APCs to 67.

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[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

CMS does not propose any new changes to the APC structure for imaging codes. The seven payment categories remain. However, CMS has move codes within these payment categories of which would cause changed pricing for 2020.

**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 |

The CMS proposes to continue paying for drugs and therapeutic radiopharmaceuticals at ASP + 6% as set forth in the CY 2010 OPPS/ASC 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.

Similar to the proposal in the Inpatient Prospective Payment System (IPPS) proposed rule, that for transformative devices that meet the FDA Breakthrough Device designation, CMS proposes to alternative pathway to qualifying for device pass-through payment status, under which the “substantial clinical improvement” criterion would not apply.

ACR staff is preparing a detailed analysis of the proposed rule and will provide additional information in the coming week.