CY 2020 Proposed Rule
Hospital Outpatient Prospective Payment System (HOPPS)
August 1, 2019

Introductory Summary

On July 29, 2019, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Hospital Outpatient Prospective Payment System (HOPPS) for CY 2020.

HOPPS Proposed Rule

The CY 2020 proposed rule is located in its entirety at the following link: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-16107.pdf

This document in PDF form is 819 pages in length. The format of the following information is intended to serve as a summary to the proposed changes and readers are encouraged to view the document in its entirety for further details.

Payment Rates

CMS is proposing an increase of payment rates under the Outpatient Department (OPD) fee schedule with a 2.7% increase to the conversion factor of CY 2019. The CY 2020 conversion factor is proposed to be $81.398; however, for hospitals that fail to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements, CMS is proposing a conversion factor of $79.770. To determine this payment rate, CMS utilized data released in the inpatient prospective payment system (IPPS) proposed ruling for FY 2020 which reflected a proposed 3.2% increase for inpatient services, minus 0.5% for the multifactor productivity (MFP) adjustment.

Based on the proposed updates to the payment rates, CMS is projecting CY 2020 HOPPS expenditures will be approximately $79 billion, an increase of approximately $6 billion compared to projected CY 2019 HOPPS payments.

CMS is proposing to maintain the rural adjustment factor of 7.1% to the OPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs) for CY 2020 and subsequent years. This payment adjustment will continue to exclude separately payable drugs, biologicals and devices paid under the pass-through payment policy. Ambulatory Surgical Center (ASC) payments are proposed to increase by 2.7% for centers that meet quality reporting under the ASCQR program.

Wage Index

CMS is proposing to continue applying a wage index of 1.000 for frontier state hospitals, this policy has been in place since CY 2011. This ensures the lower population states are not

"penalized" for reimbursement due to the low number of people per square mile when compared to other states. There are changes to the wage index values proposed as part of the IPPS FY 2020 proposed rules, which are relative population changes between urban and rural located hospitals. Overall CMS believes the updates to the wage index values will result in no estimated payment change for urban hospitals but result in an estimated 0.8% increase for rural hospitals.

Reimbursement

Cancer Hospital Payment Adjustment

CMS is proposing in CY 2020 to continue additional payments to cancer hospitals. The 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.

Beginning CY 2018, the 21st Century Cures Act required the weighted average PCR be reduced by 1.0 percentage point. CMS is proposing to use the proposed target PCR of 0.89 to determine the CY 2020 cancer hospital payment adjustment to be paid at cost report settlement. The following table reflects the 11 designated cancer hospitals and the proposed estimated increase in payments for CY 2020.

TABLE 6.—ESTIMATED CY 2020 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 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%

Standardizing APC Payment Weights

Ambulatory payment classifications (APCs) group services which are considered clinically comparable to each other with respect to the resources utilized and the associated cost. Ancillary services or items which are necessary components of the primary service are packaged into the APC rates and not separately reimbursed. CMS instructs providers to apply current procedure-to-procedure edits and then report all remaining services on the claim form. CMS will only pay for those services which are considered not packaged into another service.

CMS is proposing to continue using HCPCS code G0463, hospital outpatient clinic visit for assessment and management of a patient, in APC 5012 (Level 2 Examinations and Related Services) as the standardized code for the relative payment weights. A relative payment weight of 1.00 is proposed to be assigned to APC 5012 (code G0463). CMS is proposing use of the proposed factor of 1.00 and then dividing the geometric mean cost of each APC by the geometric mean cost of APC 5012 to derive the unscaled relative payment weight for each APC.

CY 2020 will mark the second and final adjustment year based on CY 2019 finalized changes to how the clinic visit, represented by code G0463, is reimbursed in all off-campus departments. Due to the high volume of reporting for the outpatient clinic visit billed with code G0463, CMS finalized reimbursement adjustments to the most widely reported code under HOPPS for what is seen as *"unnecessary increases in the volume of outpatient service."*

For CY 2019, CMS finalized a site-neutral method for reimbursement of code G0463. In any setting considered off-campus, more than 250 yards from the main buildings of the hospital, either excepted or nonexcepted, CMS set a site neutral rate. This means in either off-campus location the reimbursement for code G0463 would be 40% of the on-campus outpatient reimbursement. Due to the high rate change, CMS must implement over a two-year period, rather than all at once.

For CY 2019, code G0463 was set to be reimbursed a payment rate of 40% of the HOPPS rate, which is a decrease of 60%. To phase this in, the decreased amount was split in half to be phased in over two years. CY 2019 reimbursement rates for G0364 in all off-campus provider-based departments was decreased by 30%, not the full 60%. The remaining 30% will be applied in CY 2020, which brings the overall total reimbursement reduction to 60%, or payment of only 40% of the rate.

Payments of Drugs, Biologicals and Radiopharmaceuticals

Each year CMS assesses the drug packaging threshold in accordance with section 1833(t)(16)(B) of the Act. For CY 2020, CMS is proposing to package drugs and biologicals estimated at a per day administration cost less than or equal to $130, currently in CY 2019 it is set at $125. CMS has proposed to continue to pay separately for items with an estimated per day cost greater than $130 with the exception of diagnostic radiopharmaceuticals, contrast agents, anesthesia drugs, drugs, biologicals and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure, and drugs and biologicals that function as supplies or devices when used in a surgical procedure.

Payment rates for HCPCS codes for separately payable drugs and biologicals are published in Addenda A and B (for the proposed rule with comment period will be based on) Average Sales Price (ASP) data from the fourth quarter of CY 2018. This published data will be used for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective October 1, 2019. These payment rates will also be updated in the January 2020 OPPS update, based on the most recent ASP data to be used for physician's office and OPPS payment as of January 1, 2020. For items that do not currently have an ASP-based

payment rate, CMS has proposed to recalculate their mean unit cost from all of the CY 2018 claims data and updated cost report information available for the CY 2020 final rule with comment period to determine the final per day cost.

CMS also proposed to continue the policy of making packaging determinations on a drug-specific basis rather than by HCPCS code for those codes that describe the same drug or biological, but in different dosages. For all other drugs and biologicals that have HCPCS codes describing different doses, Medicare aggregated the CY 2018 claims data and pricing information at ASP+ 6 percent for all HCPCS codes that describe each distinct drug or biological. This provided the mean units per day in terms of the HCPCS code with the lowest dosage descriptor. For other drugs and biologicals that have HCPCS codes describing different doses, CMS multiplied the proposed weighted average ASP+6 percent per unit across all dosage levels of a specific drug or biological by the estimated units per day for all HCPCS codes that describe each drug or biological to determine the estimated per day cost of each drug or biological at less than or equal to the proposed CY 2020 drug packaging threshold of $130.

For CY 2020, CMS proposes to continue the current payment policy in effect since CY 2013. This payment policy pays for separately payable drugs and biologicals at ASP+6 percent. These separately payable drugs and biologicals are listed in Addenda A and B to the proposed rule. CMS is also proposing to continue to pay for separately payable non-pass-through drugs acquired with a 340B discount at ASP-22.5 percent but must address issues due to pending litigation for CYs 2018 and 2019, see section on 340B Drug Program.

For drugs or biologicals without sufficient data on sales price during the initial sales period, section 1847A(c)(4) of the Act allows for payments based on Wholesale Acquisition Cost (WAC). The Act defines certain payments must be made with a 6 percent add-on; however, the Act does not require the same add-on amount when utilizing WAC-based pricing. To be consistent with proposals outlined within the CY 2019 PFS final rule, CMS is proposing to utilize a 3 percent add-on instead of a 6 percent add-on for WAC-based drugs. For drugs and biologicals acquired under the 340B Program, the 340B Program rate (WAC minus 22.5 percent) would apply.

CMS previously finalized the payment policy for biosimilar biological products based on the payment allowance of the product as determined under section 1847A of the Act in CY 2016 and CY 2017. For CY 2020, CMS has proposed to continue the policy finalized in CY 2019 to make all biosimilar biological products eligible for pass-through payment and not just the first biosimilar biological product for a reference product. CMS has also proposed to continue to pay non-pass-through biosimilars acquired under the 340B Program at ASP minus 22.5 percent of the biosimilar's ASP instead of the biosimilar's ASP minus 22.5 percent of the reference product's ASP.

CMS has also proposed to expire pass-through status of six drugs and biologicals on December 31, 2019. These drugs and biologicals will have received OPPS pass-through payment for at least 2 years and no more than 3 years by December 31, 2019. Medicare also proposed sixty-one (61) drugs and biologicals that will continue pass-through payment status for CY 2020, which

are referenced within Table 15. For CY 2020, CMS has proposed to continue to pay for pass-through drugs and biologicals at the ASP+6 percent and continue to update pass-through payment rates on a quarterly basis through the CMS website.

340B Drug Discount Program

The 340B Drug Discount Program was established by section 340B of the Public Health Service Act by the Veterans Health Care Act of 1992 and is administered by the Health Resources and Services Administration (HRSA) within HHS. This program allows participating hospitals and other health care providers to purchase certain "covered outpatient drugs" at discounted prices from drug manufacturers.

HRSA calculates the ceiling price for each covered outpatient drug, which is the average manufacturer price (AMP) minus the unit rebate amount (URA). This ceiling price represents the maximum price a drug manufacturer can charge a covered entity for the drug. It is noted, covered entities have the option to participate in HRSA's Prime Vendor Program (PVP), which may allow for negotiation of additional discounts (known as "subceiling prices").

In the CY 2018 HOPPS final rule, CMS finalized the policy to pay for drugs purchased under the 340B Drug Discount Program (does not include drugs on pass-through payment status or vaccines) to be reimbursed at the rate of ASP minus 22.5 percent. This was significantly different than the previous rate of ASP+6 percent. Since the implementation of the drastic reduction in reimbursement for drugs purchased under 340B program (ASP-22.5 percent) lawsuits have been filed alleging CMS does not have the authority to make these changes. Recent litigation concluded, for CY 2018, Secretary Azar "*exceeded his statutory authority"* by adjusting the reimbursement rate to ASP-22.5 percent.

After request by CMS for a final judgement, so an appeal could be filed, the district court did enter final judgement on July 10, 2019. In light of this judgement, CMS is taking steps to appeal and create a policy which would address what the court sees as an overstep and the reimbursement of monies back to hospitals and adjustment to beneficiary cost-sharing. CMS is also preparing for moving forward beyond current reimbursement in CY 2019 to establish future reimbursement. In order to do this, CMS is seeking public comment on how to proceed.

Any repayment of monies back to hospitals and impacts to beneficiary cost-sharing, could have far reaching impacts. A few of the highlights for how CMS plans to do this and the comments they are seeking to assist with this plan include:

- CMS operates in a budget neutral system; reversal of the rates would impact approximately 3,900 facilities reimbursed for outpatient services and beneficiary cost-sharing to an estimated sum of $1.7 billion or CY 2018 alone. Savings from the program were distributed across all other specialties by increasing reimbursement and decreasing beneficiary expenses. This would have to be paid back to hospitals and beneficiaries may be required to pay additional monies due to the reduced rates for CYs 2018 and 2019 which would be corrected and as part of their 20 percent responsibility.

- Proposing to continue paying ASP-22.5 percent for drugs and biosimilar biologicals acquired under 340B program and furnished in nonexcepted off-campus provider-based departments paid under MPFS.
- Seeking comments for a HOPPS rate for drugs acquired under 340B program of ASP+3 percent would be appropriate and a remedial payment amount for CY 2020 and for determining how to rectify CYs 2018 and 2019.
- Seeking comments on how to structure CYs 2018 and 2019 and the potential payback scenario. Such as, should it be retrospective on a claim-by-claim basis or prospective by adjusting future claims to account for the underpayments. Also, how to address hospitals which do not acquire drugs under 340B program but respecting the need to remain budget neutral and what those adjustments may mean.
- Potentially addressing each hospital who can demonstrate harm from the underpayment and CMS would make a one-time calculated payment through their MAC. This would be done by identifying claims submitted with modifier JG for CYs 2018 and 2019. Rather than reprocessing every claim, this would be outside the normal claims processing approach.
- Seeking comments on advantages and disadvantages to spreading out over future years a budget neutral adjustment depending on the amount that is calculated as underpaid and the outcome of the appeal.

Seeking comments on the most appropriate way to address the impact to the Medicare beneficiary and the cost-sharing responsibilities for whichever solution is selected.

As outlined already, CMS is proposing to pay biosimilar biological products at minus 22.5 percent of the biosimilar's ASP, not the reference drug's ASP. Drugs not purchased under the 340B program will continue to be paid at ASP+6 percent. Hospitals will continue to report drugs purchased through the 340B Drug Discount Program with modifier JG on the same claim line items as the drug HCPCS code. Additionally, rural sole community hospitals (SCHs), children's hospitals, and PPS-exempt cancer hospitals continue to be excepted from the 340B payment adjustment and report TB modifier for 340B-acquired drugs on claim forms and paid at ASP+6 percent.

New CPT® Codes for CY 2020

CMS indicated in the CY 2020 proposed ruling it did receive timely notification of the CPT® coding changes by the American Medical Association (AMA). This allowed CMS to propose values for the new codes effective for January 1, 2020. CMS did not list the codes within the context of the rule itself but provided in an addendum.

CMS also included a table in the proposed ruling of the comment timeframe for new and revised HCPCS codes. This gives providers a better idea of when proposed coding changes are released, when comments to the changes are still accepted and when the changes would go into effect. Table 9 reflects the comment timeframe for code changes released by CMS.

TABLE 9.—COMMENT TIMEFRAME FOR NEW AND REVISED HCPCS CODES				
OPPS Quarterly Update CR	**Type of Code**	**Effective Date**	**Comments Sought**	**When Finalized**
April 2019	HCPCS (CPT and Level II codes)	April 1, 2019	CY 2020 OPPS/ASC proposed rule	**CY 2020** OPPS/ASC final rule with comment period
July 2019	HCPCS (CPT and Level II codes)	July 1, 2019	CY 2020 OPPS/ASC proposed rule	**CY 2020** OPPS/ASC final rule with comment period
October 2019	HCPCS (CPT and Level II codes)	October 1, 2019	CY 2020 OPPS/ASC final rule with comment period	**CY 2021** OPPS/ASC final rule with comment period
January 2020	CPT Codes	January 1, 2020	CY 2020 OPPS/ASC proposed rule	**CY 2020** OPPS/ASC final rule with comment period
	Level II HCPCS	January 1, 2020	CY 2020 OPPS/ASC final rule with comment period	**CY 2021** OPPS/ASC final rule with comment period

Multiple Imaging Composite APC

For those cancer centers that perform diagnostic imaging, CMS is proposing to continue to pay for all multiple imaging procedures within an imaging family performed on same date of service using multiple imaging composite APC payment methodology. Standard APC assignments will continue to apply for single imaging procedures and multiple imaging procedures performed across families. A single imaging session performed "with contrast" is part of a composite APC when at least one or more imaging procedures from the same family are also performed with contrast on same date of service. For example, if a hospital performs one MRI without contrast during same session as one with, the payment rate will be for the "with contrast" composite APC.

The five multiple imaging composite APCs established in CY 2009 are:

- APC 8004 (Ultrasound Composite);
- APC 8005 (CT and CTA without Contrast Composite);
- APC 8006 (CT and CTA with Contrast Composite);
- APC 8007 (MRI and MRA without Contrast Composite); and
- APC 8008 (MRI and MRA with Contrast Composite).

Table 5 within the CY 2020 HOPPS proposed rule contains the imaging families and multiple imaging procedure for the composite APCs.

Proposed APC 2 Times Rule Exceptions for CY 2020

CMS identified 18 APCs in which the 2 times rule violation was found. The 2 times rule does not allow the codes to be assigned to an APC where the highest costing code is more than 2 times that of the lowest costing code. When a 2 times rule violation is identified, CMS and the HOP Panel will reassign codes or create a new APC. CMS only considers HCPCS codes that are significant based on the number of claims when determining if there is a 2 times rule violation.

Table 10 lists the APCs identified as in violation of the 2 times rule but will not be adjusted.

TABLE 10.—PROPOSED APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2020	
Proposed CY 2020 APC	**Proposed CY 2020 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

Proposed Changes to Supervision of Therapeutic Outpatient Services

Since April of 2000 CMS has required direct supervision of therapeutic services in the outpatient setting. In CYs 2009, 2010 and 2011 CMS continued to clarify what direct supervision means and the expectations for meeting the requirements. During that time critical access hospitals (CAHs) and many rural hospitals pushed back citing difficulty in being able to staff or hire appropriate physicians for all therapeutic services to meet the requirement. Many stakeholders specifically called out specialty services such as radiation oncology as a difficult one to find appropriately trained physicians with that expertise for the more rural locations.

Due to this over the years CMS has enforced and then not enforced the need for direct supervision of all therapeutic services in CAHs and most recently rural hospitals with 100 or fewer beds. The most recent round of nonenforcement for CAHs and rural hospitals with 100 or fewer beds is set to expire December 31, 2019. Due to the fast approaching date, CMS has decided to review the requirement for direct supervision across the board to all hospitals regardless of size or location.

CMS expressed concern that currently there are two tiers to supervision for the same exact services. General supervision applied for CAHs and rural hospitals with 100 or fewer beds and direct supervision for all other hospitals. Additionally, CMS indicated they are not aware of any data or information that would lead them to believe the application of only general supervision in the designated areas has affected the services or care of the patients. To alleviate these differences CMS is proposing one supervision standard (general supervision) for all hospital outpatient therapeutic services provided in hospitals and CAHs.

General supervision is defined as *"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".* Direct supervision is defined as "*the physician or nonphysician practitioner must be present on the same campus where the services are being furnished"*. Additionally, the physician must be able to respond without interval of time and not be providing another service for which they cannot step away from.

CMS does stress however, if the requirement were changed to general supervision this does not prevent any of the hospitals from providing services under direct supervision when the physician administering that service determines it is appropriate to do so. There are many therapeutic services provided in the outpatient setting that are highly complex and need the direct supervision of the qualified physician.

Typically, any changes to supervision are addressed by the HOP Panel, and CMS indicated they will continue to seek their advice for appropriate supervision levels of hospital outpatient services. CMS also indicated they will retain the ability to adjust the supervision levels of individual hospital outpatient services to something more intensive than general supervision through the usual notification of changes and comment periods of the rules.

CMS also stated they are specifically seeking comments on whether specific types of services like chemotherapy administration or radiation therapy services should be excepted from this proposed change of supervision level. If they are excluded, it would mean direct supervision would be required for these therapeutic services as already required and there would not be a change except to possibly those in CAHs and rural hospitals with 100 or fewer beds who may potentially no longer be nonenforced.

Proposed Requirements for Hospitals to Make Public List of Standard Charges

Near the end of the proposed ruling CMS included a considerable amount of content applied to the proposal for hospitals to make public a list of standard charges. The Public Health Service (PHS) Act, Sec 2718 *"Bringing Down the Cost of Health Care Coverage,"* requires hospitals in the United States to make public a list of the hospital's standard changes for items and services, even diagnosis-related groups (DRGs) used for inpatient services. This concept of publishing charges for services is not new and was reclarified for reporting effective January 1, 2019, but there are some proposed changes to ensure compliance and conformity to the published data.

After stakeholder feedback as part of the FY 2020 IPPS proposed rule and in response to the June 24, 2019 Executive Order, *"Improving Price and Quality Transparency in American Healthcare to Put Patients First"* CMS is proposing some changes. These proposed changes will focus on the expansion of hospital charges to include making public negotiated rates for common shoppable services in a way that is considered consumer friendly.

CMS is proposing to add Part 180-Hosptial Price Transparency to title 45 of the Code of Federal Regulations which will contain the details of the price transparency in alignment with the

requirements of the PHS Act. CMS addresses nine different areas for proposal (see below), this summary will focus on just a few to highlight the potential changes.

(1) a definition of "hospital";
(2) different reporting requirements that would apply to certain hospitals;
(3) definitions for two types of "standard charges" (specifically, gross charges and payer specific negotiated charges) that hospitals would be required to make public, and a request for public comment on other types of standard charges that hospitals should be required to make public;
(4) a definition of hospital "items and services" that would include all items and services (both itemized and packaged) provided by the hospital to a patient in connection with an inpatient admission or an outpatient department visit;
(5) requirements for making public a machine-readable file that contains a hospital's gross charges and payer-specific negotiated charges for all items and services provided by the hospital;
(6) requirements for making public payer-specific negotiated charges for select hospital-provided items and services that are "shoppable" and that are displayed and packaged in a consumer-friendly manner;
(7) monitoring for hospital noncompliance with public disclosure requirements to make public standard charges;
(8) actions that would address hospital noncompliance, which include issuing a written warning notice, requesting a corrective action plan, and imposing civil monetary penalties (CMPs) on noncompliant hospitals and publicizing these penalties on a CMS website; and
(9) appeals of CMPs.

The items and services CMS are proposing for public listing include supplies, procedures, room and board, professional services of employed physicians and non-physician practitioners and any other services for which the hospital has a charge. The standard charges are defined as "gross charges" and "payer specific negotiated charges."

The format in which the charges are displayed is also proposed to be one in which the public can easily use without further processing or need for special software. CMS considers acceptable formats to include, but not limited to, .XML, JSON and .CSV. PDF is not considered acceptable because most consumers would be required to purchase or have access to further download or review the file. CMS did consider mandating the use of .XML only but did not want to be so defining.

Additionally, CMS is proposing all hospitals to make public payer-specific negotiated charges for as many of the 70 shoppable services in Table 37 of the proposed rule. They range from evaluation and management services, laboratory and pathology services, radiology services and medicine and surgery services. In addition to the 70 shoppable services defined by CMS, each hospital must also select at minimum another 230 shoppable services (identified by primary CPT®, HCPCS and DRG codes) to reach a total of 300 to be made public.

The services selected should be based on utilization or billing rate of the service in the past year. Updates would be at least once every 12-month period. CMS proposes the hospital would make the decision where on the website the information is housed, but it must be easy to find and "displayed prominently" and not require login or personal information to obtain so customers are not dissuaded from downloading the information.

CMS proposed and is seeking feedback on monitoring compliance. For those hospitals failing to meet the proposed standard, civil monetary penalties (CMPs) would be imposed, but each hospital would have the opportunity to take corrective action first. The proposed maximum daily dollar penalty would be $300. Regardless of how egregious or the number of violations identified, the maximum daily CMP proposed would be $300.

Submitting Comments

Comments to CMS regarding the HOPPS proposed rule must refer to file code **CMS-1717-P** and be received no later than **5 pm EST September 27, 2019**. Electronic submission is encouraged by CMS, http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.