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MEMORANDUM

To: Health Care Clients and Friends

From: Powers Firm

Date: May 21, 2020

Subject: **Proposed Changes to Medicare Hospital Inpatient Prospective Payment System (IPPS) for Federal Fiscal Year (FFY) 2021**

This memorandum summarizes key changes to the acute-care hospital IPPS proposed by the Centers for Medicare and Medicaid Services (CMS) for FFY 2021. CMS issued a display copy of the proposed rule on May 11, 2020. The proposed rule is scheduled to be published in the Federal Register on May 29. Comments are due by 5:00 pm Eastern on July 10, 2020. The tables and data files for the proposed FFY 2021 IPPS rule are available on the FFY 2021 Proposed Rule Home Page.

Due to the COVID-19 public health emergency, CMS is waiving the requirement for a 60 day delay in the effective date of the rule and will allow a 30 day delay in the effective date of the rule. This means that CMS will not be publishing the final rule by August 1 and instead will publish it by September 1 at the latest with an October 1 effective date. As a practical matter, providers will have less time to adjust to any rules that are finalized.

Among the proposed IPPS changes are the following:

- **IPPS Updates**

The proposed IPPS increase in operating payment rates for acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 3.1%. CMS projects that the rate increase, together with other proposed changes to IPPS payment policies, will increase IPPS operating payments by approximately 2.5%, and that proposed changes in uncompensated care payments, capital payments and low-volume hospital payments will decrease IPPS operating payments by an additional 0.4% for a total increase of overall IPPS payments of approximately 1.6%.

The tables below show the proposed updates to the standardized amounts for FFY 2021.

Table 1A. – Proposed Rule National Adjusted Operating Standardized Amounts; Labor/Nonlabor (68.3 Percent Labor Share/31.7 Percent Nonlabor Share If Wage Index Greater Than 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.6 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.35 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.85 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.4 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,084.16	$1,895.58	$3,994.60	$1,854.01	$4,054.31	$1,881.72	$3,964.74	$1,840.15

Table 1B. – Proposed Rule National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Less Than Or Equal To 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.6 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.35 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.85 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.4 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,707.44	$2,272.30	$3,626.14	$2,222.47	$3,680.34	$2,255.69	$3,599.03	$2,205.86

Table 1D. – Proposed **Capital** Standard Federal Payment Rate: $468.36

Table I in the proposed rule (starting on p. 1,482 of the display copy) shows the estimated impact of all the proposed changes on Medicare hospitals. The explanation of Table I is on page 1,480 of the display copy.

- **Medicare-Severity Diagnosis Related Group (MS-DRG) Data Collection and Change in Methodology for Calculating MS-DRGs (p. 944 – 952)**

MS-DRG weights are currently calculated based on hospital cost to charge ratios (CCR) reported on the Medicare cost report and the gross charge data for the CCR is obtained from a hospital's chargemaster. In the proposed rule, CMS states that gross chargemaster rates "rarely reflect the true market costs or prevailing market rates." CMS is proposing to transition to calculating MS-DRG weights based on the negotiated charges from Medicare Advantage

Organizations (MAOs). CMS requests comments on its plan to use the MAO charge data to calculate MS-DRG relative weights beginning in FFY 2024 and is requesting comments on alternative methodologies.

To collect this charge data, CMS is proposing to require hospitals to report negotiated payer charges on Medicare cost reports for cost-reporting periods ending on or after January 1, 2021. For each MS-DRG, hospitals would report: (1) the median payer-specific negotiated charge that the hospital has negotiated with all of its MAOs and (2) the median payer-specific negotiated charge that the hospital has negotiated with all of its third-party payers, which may include MAOs, by MS-DRG. The hospital's charge data will be deidentified and made publicly accessible in the Healthcare Cost Report Information System (HCRIS). CMS notes that the payer-specific negotiated charges used by hospitals to calculate the median charge would the be the payer-specific negotiated charges that hospitals are already required to make public under 45 C.F.R. § 180.50 (the Hospital Price Transparency rule).[1]

- **Disproportionate Share Hospital (DSH) and Uncompensated Care Pool Payments (p. 798 – 863)**

Since FFY 2014, eligible hospitals have received DSH payments equal to 25% of traditional DSH payments as calculated at 42 U.S.C. § 1395ww(d)(5)(F). CMS refers to this 25% payment as the "empirically justified DSH payment." In addition, eligible hospitals receive a payment that is based on an "uncompensated care pool." Specifically, the additional DSH payment is calculated using three factors: 1) 75% of the payments that would have been made to all hospitals under 42 U.S.C. § 1395ww(d)(5)(F); 2) the percentage change in the uninsured population since 2013; and 3) the ratio of each hospital's uncompensated care to uncompensated care for all DSH hospitals. A hospital's payment from the uncompensated care pool is the product of these three factors.

CMS proposes to continue its prior policy for Factor 1 in FFY 2021. CMS estimates that total DSH payments under section 1305ww(d)(5)(F) would have been $15,358,534,714.46, based on the Office of the Actuary's December 2019 estimate. CMS thus proposes that the Factor 1 amount will be $11,518,901,035.84 (75% of $15,358,534,714.46).

Factor 2 is an adjustment equal to 1 minus the percentage change in the national rate of uninsurance for the current year as compared to a base of 2013. Previously, CMS used Congressional Budget Office (CBO) uninsured population estimates for the under 65 population

[1] CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65,524, 65,538 (Nov. 27, 2019) (this final rule requires hospitals to make standard charges public and provide certain shoppable services online in an easily accessible and consumer-friendly manner. Standard charge data that must be published includes the hospital's (1) gross charge; (2) payer-specific negotiated charge (including DRGs); (3) deidentified minimum negotiated charge; (4) deidentified maximum negotiated charge; and (5) discounted cash price). Several organizations, including the American Hospital Association, filed suit in the U.S. District Court for the District of Columbia challenging the transparency final rule. Complaint, *Am. Hosp. Ass'n. v. Azar*, No. 1:19-cv-03619 (D.D.C. Dec. 4, 2019).

in calculating Factor 2, but the statute allows the use of other data sources beginning in FFY 2018. For FFY 2018 through FFY 2020, CMS used uninsured estimates produced by the Office of the Actuary as part of the development of the National Health Expenditure Accounts (NHEA), which reflect the rate of uninsurance in the U.S. across all age groups. In addition, CMS calculates the current-year rate of uninsurance based on a weighted average of the uninsurance estimate for the current and prior calendar years (CY).

CMS proposes to continue this methodology in FFY 2021. Using the NHEA data, CMS estimates that the uninsurance rate for CYs 2020 and 2021 will be 9.5% in each year. Compared to the 2013 base rate of 14% (also now calculated based on NHEA data), this represents a percentage change of 32.14%, which, when subtracted from 1, equals an adjustment of 67.86%. This results in a proposed total uncompensated care pool of $7,816,726,242.92 (i.e., 67.86% times $11,518,901,035.84).[2]

Factor 3 is each eligible DSH hospital's estimated uncompensated care amount relative to the estimated uncompensated care amount for all eligible DSH hospitals. For FFY 2014, CMS decided to use insured low-income patient utilization, defined as Medicaid inpatient days plus Medicare SSI inpatient days, as a proxy for uncompensated care, and this was also used for FFYs 2015, 2016, and 2017. In FFY 2018, CMS adopted a proposal to use data from Worksheet S-10 of the Medicare cost report to calculate Factor 3.

In FFY 2021, CMS proposes to use FFY 2017 Worksheet S-10 data to calculate Factor 3 for all eligible hospitals except Indian Health Service (IHS) hospitals, Tribal hospitals, and Puerto Rico hospitals. For these latter three groups of hospitals, CMS will continue to use low-income insured days as a proxy to calculate Factor 3. In FFY 2022 and all future years, CMS proposes to calculate Factor 3 using Worksheet S-10 data for the most recent cost reporting year that has been audited for a significant number of hospitals receiving substantial Medicare uncompensated care payments (with the exception of IHS and Tribal hospitals). CMS proposes to continue to define "uncompensated care" in FFY 2021 and all future years as Line 30 of Worksheet S-10.

Similar to previous years, CMS performed the proposed the Factor 3 calculation using HCRIS data updated through February 19, 2020. CMS proposes to use the March 2020 update to HCRIS to calculate Factor 3 in the final rule, and CMS would use the March updates to calculate Factor 3 in all future final rules. CMS also proposes revisions to its methodology for calculating Factor 3 for merged hospitals and for hospitals with cost reporting periods longer than 12 months.

Beginning in FFY 2022, CMS proposes to create a new DSH payment for IHS and Tribal hospitals that would be based on the traditional DSH payment under 42 U.S.C. §

[2] The proposed rule erroneously states that the uncompensated care pool of $7,816,726,242.92 is equal to 67.86% of $15,358,534,714.46, which is incorrect. The $7,816,726,242.92 pool is actually equal to 67.86% of the Factor 1 amount of $11,518,901,035.84.

1395ww(d)(5)(F). The payment would be based on 100% of the traditional DSH payment, rather than 25%.

CMS will publish on its website a table listing Factor 3 for all hospitals that it estimates will receive DSH payments for FFY 2021. CMS will also publish a supplemental data file with a list of the hospital mergers that CMS is aware of and the computed uncompensated care payments for each merged hospital. Hospitals should notify CMS within 60 days from the date of public display of the proposed rule of any inaccuracies. The proposed rule also notes that after publication of the FFY 2021 final IPPS rule, hospitals will have fifteen business days to again review and submit comments on the accuracy of the table, which is less time than in previous years.

- **Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) (p. 923 – 930)**

CMS proposes to keep the IME adjustment factor at 1.35 as required by statute.

Current regulations permit hospitals to receive temporary increases to their DGME and IME full-time equivalent (FTE) caps if they train residents who are displaced from another hospital due to the closure of a residency program or closure of the hospital. CMS's policy is to define a resident as displaced if the resident was physically present either the day before or the day of the closure of the hospital or program. CMS also considers a resident to be displaced if he or she is on an approved leave of absence on the day prior to or the day of the closure. CMS proposes to add a new definition of "displaced resident" at 42 C.F.R. § 413.79(h)(1)(iii) that will expand the circumstances under which a resident is considered displaced. Under the new definition, residents who are training at the closing hospital or program on the day before or the day of closure (or were on approved leaves of absence on those days) will continue to be considered displaced. In addition, the following categories of residents will also be considered displaced:

  - Residents who leave a program after closure is publicly announced, but before the actual hospital or program closure;
  - Residents assigned to and training at planned rotations at another hospital who will be unable to return to their rotations at the closing hospital or program;
  - Residents who are matched into a GME program at the closing hospital or program but have not yet started training at the closing hospital or program; and
  - Residents on approved leave at the time of the announcement of closure, and therefore, cannot return to their rotations at the closing hospital or program.

- **Medicare Bad Debts (p. 1207 – 1245)**

CMS is proposing "to clarify, update and codify certain longstanding Medicare bad debt principles into the regulations…". CMS is also proposing to recognize Accounting Standards Update – Topic 606 for revenue recognition and classification of Medicare bad debts.

- **Definition of Non-Indigent Beneficiary**

CMS is proposing to amend the Medicare regulations to define a "non-indigent" Medicare beneficiary as a beneficiary who has not been determined to be categorically or medically needy to receive Medicaid and has not been determined to be indigent by the provider for Medicare bad debt purposes. The definition of non-indigent Medicare beneficiary is important because a provider is required to engage in "reasonable collection efforts" under section 310 of the Provider Reimbursement Manual (PRM) only for non-indigent Medicare beneficiaries. This proposal would be effective retroactively.

- **Reasonable Collection Efforts – Issuance of an Initial Bill**

PRM section 310 states that a reasonable collection effort must involve the issuance of a bill on or "shortly after" discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. CMS is proposing to include this provision in the regulations, effective for cost reporting periods beginning before October 1, 2020. Effective for subsequent cost reporting periods, CMS is proposing to add a provision to Medicare regulations to state that a reasonable collection effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after: (1) the date of the Medicare remittance advice; or (2) the date of the remittance advice from the beneficiary's secondary payer, if any; whichever is latest.

- **Reasonable Collection Efforts – Clarification of Required Efforts and Documentation**

CMS is proposing to clarify that a provider's collection effort for Medicare non-indigent patient must be similar to the effort that the provider or a collection agency puts forth to collect "comparable amounts" from non-Medicare patients.

CMS is also proposing to amend the regulations to state that, in addition to sending the non-indigent beneficiary an initial bill, the provider's reasonable collection effort must include subsequent billings, collection letters, and telephone calls or personal contacts that "constitute a genuine, rather than token, collection effort." The provider must maintain documentation of its bad debt collection policy that describes its collection process for Medicare and non-Medicare patients; the beneficiary's account history documents which show the dates of various collection actions including invoices; follow-up collection letters; reports of telephone calls and personal contacts or similar collection activities; and the beneficiary's file with copies of the bill(s) and follow-up notices. These changes to the Medicare regulations would be effective retroactively.

- **Reasonable Collection Efforts – Partial Payments and Effect on 120-Day Collection Period**

Providers are permitted to deem a bad debt uncollectible if it remains unpaid for 120 days after the initial bill is sent. CMS is proposing to add a provision to the Medicare regulations to state that, when the provider receives a partial payment within the minimum 120-day required collection effort period, the provider must continue the collection effort and that the day the partial payment is received is day one of the new collection period. The provider is permitted to end the collection effort at the end of a 120-day period when no payments have been received during those consecutive 120 days. These provisions would be effective retroactively.

- **Reasonable Collection Effort – Accounting for Bad Debt Recovery**

CMS is proposing to amend the Medicare regulations to incorporate provisions in PRM § 316 to state that uncollected deductible and coinsurance amounts are to be written off and recognized as allowable bad debts in the cost reporting period in which the accounts are deemed to be worthless. If any amounts are collected before the end of that cost reporting period, those amounts should reduce the bad debt claimed in that period. This change would be effective retroactively.

- **Reasonable Collection Effort – Additional Requirements Related to Collection Agencies**

CMS is proposing to amend the Medicare regulations to state that a provider that uses a collection agency must: (1) reduce the beneficiary's account receivable by the gross amount collected by the agency; (2) include any fee charged by the collection agency as an administrative cost; and (3) before claiming the unpaid amounts as a Medicare bad debt, cease all collection efforts, including the collection agency efforts, and ensure that the collection accounts have been returned to the provider from the agency. The preamble states that collection accounts that remain at a collection agency, even if they are monitored only passively by the agency, cannot be claimed by the provider as a Medicare bad debt. The preamble includes an example of accounting for a collection agency's administrative fees under a percentage arrangement and an example for a flat fee arrangement. This change would be effective retroactively.

- **Determining Indigence**

CMS is proposing to add a provision to the Medicare regulations to state the factors that a provider must consider in determining that a patient is indigent, which allows the provider to write off the bad debt without a collection effort. Specifically, the provider must have proof of a beneficiary's inability to pay his or her medical bills independent of the beneficiary's statement. The provider must consider the beneficiary's: (1) assets that are convertible to cash and unnecessary for the beneficiary's daily living; (2) liabilities; (3) income; and (4) expenses. The provider should consider any extenuating circumstances that would affect the beneficiary's ability to pay and determine that there

are no third parties that are legally responsible for the beneficiary's medical bills. The provider must maintain documentation of its indigency policy and documentation to support its determination of a beneficiary's indigence or medical indigence. This provision would be effective retroactively.

- **CMS "Must Bill" Policy for Dual Eligible Beneficiaries**

An issue that has been litigated frequently is CMS's "must bill" policy for Medicare and Medicaid dual eligible beneficiaries. Under this policy, which is described in PRM section 312, providers seeking Medicare reimbursement for bad debts for dual eligible beneficiaries are required to: (1) bill the Medicaid program to determine that there is no source, other than the patient, that would be legally responsible for the patient's medical bill; and (2) obtain and submit to the Medicare Administrative Contractor (MAC), a Medicaid remittance advice (RA) from the State Medicaid program. Providers have struggled to comply with the "must bill" policy because some State Medicaid programs will not issue an RA if the Medicaid agency does not have an obligation to pay the Medicare co-payment.

CMS is proposing to include the "must bill" policy in the Medicare regulations and make it effective retroactively. CMS recognizes that not all states will issue an RA in response to a provider's submission of a claim for a dual eligible beneficiary, particularly when the state follows a general policy of not making payments on these claims. Therefore, CMS is also seeking comments on whether it should accept an alternative to the RA to demonstrate a state's Medicare cost sharing liability or lack of cost sharing liability. CMS is also seeking comments on whether it would apply this policy of allowing alternative documentation retroactively, including whether a retroactive effective date "would serve an important public interest by allowing providers with cases currently pending [on this issue] before the PRRB an avenue for timely and cost-effective resolution." Providers with cost report appeals pending on this issue, or that anticipate that they will be appealing this issue, should submit comments supporting use of alternative documentation to the RA with a retroactive effective date.

- **Conformance with the Financial Accounting Standards Board's (FASB) Accounting Standards**

The FASB's Accounting Standards Update (ASU) 2014-09, Revenue from Contracts with Customers (Topic 606), ("ASU Topic 606"), was published in May 2014 with the first implementation period in 2018. ASU Topic 606 made changes with respect to revenue recognition of patient-related bad debts and uncollectible accounts, as well as changes to terminology and definitions related to bad debts. CMS is proposing to incorporate these changes in the Medicare regulations. Specifically, CMS is proposing to incorporate the definition of "implicit price concessions" as another name for bad debts and to define charity, and courtesy allowances as reductions in revenue rather than additional costs of providing services. CMS is proposing to adopt these changes effective

for cost reporting periods beginning on or after October 1, 2020. CMS states that these changes will not affect the criteria a provider must meet to qualify a beneficiary's bad debt account for Medicare bad debt reimbursement. Some providers have reported, however, that Palmetto has been disallowing bad debts that providers had charged to a contractual allowance account rather than an expense account, so MACs may try to use this new rules as a reason to make disallowances in the future.

- **Contractual Allowances**

  CMS is also proposing to amend the Medicare regulations to state that Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (bad debts or, under the new ASU Topic 606 terminology, implicit price concessions). This change would be effective for cost reporting periods beginning on or after October 1, 2020,

- **Provider Reimbursement Review Board (PRRB) Electronic Filing (p. 1,202-1,207)**

On August 16, 2018, the PRRB launched the OH Case and Document Management System (OH CDMS), a web-based portal that allows providers to submit filings electronically and view MAC filings through the portal. In the proposed rule, CMS announces that no earlier than FFY 2021, the PRRB may require that all new submissions must be electronically filed via OH CDMS. Accordingly, CMS proposes to amend its regulation to make clear that parties to an appeal must familiarize themselves with all requirements related to the electronic filing of documents. CMS notes that the PRRB would provide at least 60 calendar days' notice before requiring electronic filing.

- **Hospital Inpatient Quality Reporting (IQR) Program (p. 1,090-1,139)**

  CMS proposes the following with respect to the Hospital IQR Program:

  - CMS proposes to progressively increase, over a three-year period, the number of quarters for which hospitals are required to report electronic clinical quality measure (eCQM) data from one self-selected quarter of data to four quarters of data. For more information, please refer to pages 1,100-01.

  - CMS proposes to continue the policy that requires hospitals to use EHR technology certified to the 2015 Edition to submit data on the Hybrid Hospital-Wide Readmission Measure with Claims and EHR Data and expand this requirement to apply to any future hybrid measure adopted into the Hospital IQR Program's measure set. CMS also clarifies that core clinical data elements and linking variables must be submitted using the Quality Reporting Document Architecture Category I file format for future hybrid measures in the program. Please refer to page 1107 for addition information.

- CMS proposes to combine the validation processes for chart-abstracted measure data and eCQM data and related policies in a stepwise process. To accomplish this, CMS proposes to:

  - Update the quarters of data required for validation for both chart-abstracted measures and eCQMs;
  - Expand targeting criteria to include hospital selection for eCQMs;
  - Change the validation pool from 800 hospitals to 400 hospitals;
  - Remove the current exclusions for eCQM validation selection;
  - Require electronic file submissions for chart-abstracted measure data;
  - Align the eCQM and chart-abstracted measure scoring processes; and
  - Update the educational review process to address eCQM validation results.

For more information, please refer to pages 1,110-32.

- CMS proposes to begin publicly reporting eCQM data beginning with the eCQM data reported by hospitals for the CY 2021 reporting period/FFY 2023 payment determination. This data could be made available to the public as early as Fall 2022. Please refer to pages 1,137-38 for more information.

- For information on reporting and submission requirements for eCQMs, including proposed reporting and submission requirements for future reporting periods and payment determinations, please refer to pages 1,101-05.

- **Hospital-Acquired Condition (HAC) Reduction Program (p. 911-922)**

  In the proposed rule, CMS addresses the following HAC Reduction Program policies:

  - CMS proposes to implement the applicable period for the FFY 2023 HAC Reduction Program for the CMS PSI 90 measure as the 24-month period from July 1, 2019 through June 30, 2021. CMS also proposes to implement the applicable period for the CDC National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measure as the 24-month period from January 1, 2020 through December 31, 2022. For more information, please refer to pages 914-15.

  - CMS proposes that hospitals must submit digital files when submitting medical records for validation of HAC Reduction Program measures, beginning with the FFY 2024 program year. Under this proposal, hospitals would no longer be able to send CD, DVD, or flash drives containing digital images of patient charts. Please refer to pages 919-21 for more information.

  - CMS proposes to reduce the total number of hospitals that may be selected for validation under the HAC Reduction Program from up to 600 to up to 400 hospitals, effective with validation for the FFY 2024 program year. CMS will continue to select up to 200

hospitals using targeting criteria; however, CMS proposes to reduce the randomly selected hospital pool from up to 400 hospitals to up to 200 hospitals. For more information, please refer to page 919.

- To align the quarters used for HAC Reduction Program and Hospital IQR validation, CMS proposes to only use measure data from the third and fourth quarters of 2020 for the FFY 2023 program year. For the FFY 2024 program year and subsequent years, CMS proposes to use measure data from all quarters of CY 2021 for the HAC Reduction Program and the Hospital IQR Program. For more information, please refer to pages 917-918.

- **Hospital Readmissions Reduction Program (HRRP) (p. 877-887)**

CMS proposes the following with respect to the HRRP:

- CMS proposes that for FFY 2023, the applicable period for the HRRP measures and for determining dual eligibility would be the three-year period from July 1, 2018 through June 30, 2021. Please refer to pages 879 and 881-82 for more information.

- For FFY 2021, CMS proposes to determine aggregate payments for excess readmissions and aggregate payments for all discharges using data from MedPAR claims with discharge dates that align with the FFY 2021 applicable period. For more information, please refer to pages 882-84.

- **Hospital Value-Based Purchasing (VBP) Program (p. 888-911)**

CMS estimates that approximately $1.9 billion is available for value-based incentive payments for FFY 2021, but CMS will update this estimate in the final rule using the March 2020 update of the FFY 2019 MedPAR file. CMS published its proxy value-based incentive payment adjustment factors, which are based on the Total Performance Score (TPS) from FFY 2020. CMS will update these figures in the final rule to reflect changes based on the March 2020 update to the FFY 2019 MedPAR file. Hospitals will be given an opportunity to review and correct their TPSs for the FFY 2021 program year after the final rule is published. CMS will then publish the actual value-based incentive payment adjustment factors and estimated amount available for FFY 2021 in the fall of 2020.

CMS addresses the following topics with respect for the Hospital VBP Program:

- For details regarding previously adopted Hospital VBP Program measures and measure removal factors, please refer to page 891. CMS is not proposing any changes to these policies at this time.

- For a summary of CMS's previously adopted measures for the FFY 2022 and FFY 2023 program years, please refer to pages 891-92. CMS is not proposing any changes to these measures at this time.

- For details regarding previously adopted baseline and performance periods, please refer to pages 893-99. CMS is not proposing any changes to these policies at this time.

- For details regarding proposed and previously adopted performance standards for various program years, please refer to pages 899-906.

- For details regarding previously adopted domain weighting policies, the minimum number of measures for Hospital VBP Program domains, and the minimum number of cases for Hospital VBP Program measures, please refer to pages 906-08. CMS is not proposing any changes to these policies at this time.

- For details regarding previously adopted administrative policies for NHSN HAI measures, please refer to page 910.

- **Medicare and Medicaid Promoting Interoperability Programs (formerly the EHR Incentive Program) (p. 1,157-1,176)**

For CY 2022, CMS proposes a minimum EHR reporting period of any continuous 90-day period in CY 2022 for new and returning participants (eligible hospitals and critical access hospitals (CAHs)) in the Medicare and Medicaid Promoting Interoperability Programs. CMS is not proposing to define the EHR reporting period in CY 2022 for the Medicaid Promoting Interoperability Program because the program will end with CY 2021. For more information on the proposed EHR reporting periods, please refer to pages 1,158-59.

In the FFY 2020 final rule, CMS finalized changes to the Query of Prescription Drug Monitoring Program (PDMP) measure under the Electronic Prescribing Objective, including making this measure optional for CY 2020. CMS acknowledges that additional time is needed prior to requiring a Query of PDMP measure for performance-based scoring and proposes to maintain this measure as optional for CY 2021. This proposal is discussed in greater detail on pages 1,159-66. Under the Health Information Exchange Objective, CMS proposes to change to the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure, as discussed on pages 1,166-67. The impact of these changes on the scoring methodology for eligible hospitals and CAHs is discussed on pages 1,167-68.

CMS proposes to increase the number of quarters for which eligible hospitals and CAHs are required to report eCQMs from one self-selected calendar quarter of data to four calendar quarters of data over a three-year period. The proposed changes to the eCQM reporting periods for CY 2021 and CY 2022 are discussed on pages 1,169-71. For CY 2023 and each subsequent year, CMS proposes to require eligible hospitals and CAHs to report four calendar quarters of data for three self-selected eCQMs (based on the set of available eCQMs for CY 2023 and each

subsequent year) as well as for the Safe Use of Opioids—Concurrent Prescribing eCQM. CMS proposes to align with the Hospital IQR Program and publicly report eCQM data that is submitted by eligible hospitals and CAHs, stating for the CY 2021 reporting period. For further details regarding the proposed public reporting of eCQM data, please refer to pages 1,171-74.

CMS is soliciting comments on how Medicare can support overlap between the Promoting Interoperability Programs and the 21st Century Cures Act. For further details regarding the future of the Promoting Interoperability Programs and the proposed technical corrections to the regulatory text, please refer to pages 1,174-76.

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If you have any questions, please call, Barbara Straub Williams, Ron Connelly, Leela Baggett, or the attorney with whom you usually work at (202) 466-6550.