August 27, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

SUBJECT: CMS-1747-P, Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Update: Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-term Care Hospital Quality Reporting Program Requirements; Federal Register (Vol. 86, No.127), July 7, 2021

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, including numerous home health agencies (HHAs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) Home Health (HH) Prospective Payment System (PPS) proposed rule for calendar year (CY) 2022.

Our comments are made in the context of the first full year of implementation of the Patient-Driven Grouping Model (PDGM), which went into effect in January 2020 and included wide-ranging changes to case-mix methodology and HHA payment policies. The simultaneous implementation of a new benefit for infusion therapy services required additional changes in documentation, billing, and care coordination for home health beneficiaries receiving infusion therapy. The scope and pace of these changes has challenged HHAs to not only develop and implement significant modifications in operations and workflow, but also to provide additional education and training to staff — all while continuing to deliver home health care services in their communities.

Additionally, the ongoing COVID-19 public health emergency (PHE) continues to impact our health care system. Care providers at all levels are experiencing major changes in the types of patients they are seeing, their care needs, and how and where care is delivered. Adjusting to these changes requires significant investment of time and resources.

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A significant consequence of the COVID-19 PHE is the recognition of the unique value and role of home health care, including how home health services can improve outcomes and control costs. Any changes to home health policy and payment must consider these unique circumstances and the lessons we have learned during this difficult time.

CHA supports and appreciates CMS' proposals to:

- **Defer implementation of a behavioral assumption payment adjustment.** We continue to believe that any future adjustments must be supported by additional information and data, and include analysis of the projected impact on different types of HHAs, particularly those operated by hospitals or health systems.
- **Update the conditions of participation to allow occupational therapists to complete assessments when certain conditions are met, and to provide flexibilities in the supervision of home health aides.**

However, CHA has several concerns about specific provisions of the proposed rule. We urge CMS to:

- **Delay the proposed expansion of the HH Value-Based Purchasing (VBP) Program.** Additional information and analysis, including consideration of the impact on hospital-based HHAs, is needed to support the change.
- **Solicit broad stakeholder input on VBP Program design in future rulemaking.**
- **Reconsider its proposal to revise the compliance date for reporting requirements for the HH quality reporting program (QRP), the inpatient rehabilitation facility (IRF) QRP and the long-term care hospital (LTCH) QRP.** We believe this revision is unwise given the ongoing challenges of the COVID-19 PHE. Further, the proposal does not provide sufficient time for staff training and development, or for implementation of associated operational changes.

Payment and Case-Mix Updates

CHA appreciates CMS' efforts to monitor the impact of changes implemented as part of the PDGM, including replacing 60-day episodes of care with 30-day periods of care, removing therapy volume as a determinant for payment, and developing new case-mix adjusted payment groups. Assessing the impact of these changes on patient access, outcomes, and resource use is critical to developing future changes to home health policy. CHA appreciates the data and observations offered by CMS in the current proposed rule.

CHA also appreciates CMS' recognition that greater-than-anticipated 30-day episode costs may be attributable to increased telecommunication and personal protective equipment (PPE) costs incurred by HHAs during the pandemic, as well as its willingness to update period of care costs in future rulemaking. **However, CHA remains concerned that the analysis does not adequately acknowledge the significant impact of the ongoing COVID-19 pandemic.**

The COVID-19 PHE started just a few short weeks after the implementation of the PDGM. It has had — and continues to have — wide-ranging impacts on multiple aspects of home health operation. For example, concerns about virus spread as well as limitations in the supply of necessary PPE led to reductions in the number, frequency, and type of in-home visits. These changes, in turn, resulted in fewer episodes of care, fewer visits per episode, and a greater number of low-utilization payment adjustment

visits. Additionally, many agencies reported reductions in non-nursing visits (e.g., therapist, home health aide, social worker), based on patient request or staff limitations.

These utilization changes are very similar to those anticipated to result from PDGM implementation. At this time, it is impossible to distinguish the portion of the observed change that is attributable to provider behavioral changes associated with PDGM from the portion that is a consequence of HHA response to the pandemic.

CHA strongly urges CMS to extend this monitoring through and beyond the PHE, in order to evaluate the impact of the PDGM as well as to assess both the short- and long-term changes that may result from the pandemic. A clear understanding of the various factors contributing to utilization changes will be critical to informing future policy changes.

BEHAVIORAL OFFSETS

The Balanced Budget Act of 2018 required the Secretary to make certain assumptions about changes in patterns of service delivery that might occur due to the change in the unit of payment from a 60-day episode of care to a 30-day period of care. Beginning in 2020 and ending in 2026, the Secretary must determine, for each year, the difference between the estimated impact of the behavior changes it assumed and make offsetting adjustments as indicated. In the CY 2020 final rule, CMS finalized the application of a behavioral offset.

In the current proposed rule, CMS reports that the 2020 30-day base payment rate was approximately 6% higher than it should have been to maintain budget neutrality, attributable to a change in case mix. CMS notes that a temporary retrospective adjustment for 2020 and subsequent years may be necessary until a permanent prospective adjustment can be made.

CHA supports CMS' decision to defer implementation of a payment adjustment at the current time. Additionally, future adjustments should be accompanied by additional evidence and information to support specific assumptions and the associated financial impact.

Assessment of provider behavior changes must also consider the impact of the COVID-19 PHE on HHAs and their patient care operations. While CHA applauds CMS' recognition that its analysis may change as more 2020 claims become available, we are concerned that CMS does not adequately recognize the significant and ongoing impact of the COVID-19 PHE. Our members report that utilization patterns and labor costs have been significantly affected, resulting in increased costs per episode. It is likely that many of these changes will persist beyond the PHE, reflecting structural changes made necessary by the pandemic rather than behavioral change. CHA urges CMS to use the delay in implementation of the behavioral offsets to reassess the need for future adjustments.

CHA continues to be concerned that HHAs operated by hospitals or health systems are disproportionately impacted by the application of the behavioral offsets, which are applied on an aggregate basis. Compared to free-standing HHAs, hospital/health system agencies care for a wider range of medically complex patients and often operate at minimal — or even negative — Medicare margins. A "one-size-fits-all" reduction to the standard payment rate, as proposed, unfairly penalizes those agencies. Moreover, the many changes to the PPS in recent years — including rebasing, legislative

cuts, and limitations to home health payments — have disproportionately affected the HHAs that care for the most medically complex and frail patients.

We reiterate our previous requests that CMS provide additional information and data to support its current assumptions about the impact of provider behavior changes on payment, including an analysis of the projected impact on different types of HHAs, such as those operated by hospitals or health systems.

FUNCTIONAL IMPAIRMENT LEVELS

Under the PDGM, the functional impairment level is determined by responses to certain OASIS items associated with activities of daily living and risk of hospitalization. A home health period of care receives points based on responses from these functional OASIS items, which are converted to a table of points. The sum of all these points is used to group home health periods into low, medium, and high functional impairment levels, designed so that about one-third of home health periods fall within each level.

For 2022, CMS proposes to use the 2020 claims data to update the functional points and functional impairment levels by clinical group, and use the same previously finalized methodology to update the functional impairment levels for CY 2022. While we support this plan to update current measures' functional points values and functional impairment levels, we urge CMS to share additional information about a future transition to the use of the standardized patient assessment items included in Section GG, which HHAs began collecting as part of the OASIS beginning in January 2019.

Section GG includes several standardized patient assessment data elements that are incorporated in the case-mix methodology for each of the other post-acute care settings, including LTCHs, IRFs, and skilled-nursing facilities (SNFs). As such, Section GG is a key component in CMS' plans to standardize patient assessment and quality reporting across the post-acute continuum of care.

CMS notes that, while preliminary analysis shows a high correlation between the current M1800-1860 and Section GG, it will continue to collect data to assess the effect of these items on resource use during a home health period of care. We encourage and support CMS' plans to assess the relationship of Section GG items to resource use and their correlation to the current OASIS items that address functional status, and we urge CMS to prioritize and expedite this process.

HH VALUE-BASED PURCHASING

The HH VBP model was established in the 2016 HH PPS final rule (80 FR 68624) as a five-year test by the Center for Medicare and Medicaid Innovation (the Innovation Center). Under the program, payments to participating HHAs are adjusted upward or downward based upon performance on a set of pre-defined quality measures. On January 8, 2021, CMS announced that the HH VBP Model had been certified for expansion through rulemaking under section 1115(a) of the Act. The certification for expansion was based upon the model's performance over its first three performance years (CY 2016-2018) and expansion was set to occur to occur no earlier than CY 2022.

CMS reports that the model was found to improve the quality of care provided by HHAs, shown by higher performance scores in HH VBP states versus non-HH VBP states, and to reduce Medicare expenditures through decreased emergency department (ED), inpatient hospital, and SNF utilization. As

a result, CMS proposes to expand the HH VBP model nationwide, with mandatory participation for all Medicare-certified HHAs.

While CHA supports the development and implementation of value-based payment reforms that support the delivery of high-quality care and the achievement of optimal patient outcomes, we believe CMS' proposed plan to proceed with a nationwide expansion of the HH VBP model is premature. We appreciate CMS' acknowledgement that improved performance at one level of care will impact utilization and resource use in other parts of the health care continuum. By enhancing the quality of home health care, hospitalizations and ED visits can be reduced.

However, the proposed timeline for national expansion does not sufficiently allow for learnings from the more limited model to inform program design going forward. Moreover, the ongoing COVID-19 PHE has brought to the forefront the unique role of home health care and compels us to carefully assess how services can be redesigned to better meet the needs of our most vulnerable patients. It is critical that providers and regulators alike have access to complete data from the test model and sufficient time to absorb the learnings of the pandemic prior to the implementation of broad changes to payment policy, such as a nationwide mandatory VBP model.

CHA urges CMS to delay nationwide expansion of HH VBP, continue the current model though its originally planned five-year test period, and solicit broad stakeholder input on VBP design in future rulemaking. A delay is necessary to allow adequate time for thoughtful and considered review of model results to date and to solicit additional input from all HH providers — in both HH VBP states and non-HH VBP states, regarding changes and implementation going forward.

The current VBP model, which was implemented in 2016, was originally planned to run for a full five years. A five-year term would allow the agency to assess the impact of gradually increasing incentive payments, and — perhaps more importantly — whether year-over-year improvements could continue and be sustained over time. Because the financial impact of performance did not affect the HHA until two years later, conducting the model for multiple years was necessary to assess the program's true impacts, both positive and negative. Terminating the test program early limits the information we have about these critical issues.

For example, CMS states that under the VBP model, performance scores for HHAs in HH VBP states were higher than those in non-HH VBP states. While this result is promising, we believe that additional information regarding the nature and degree of the changes is needed to inform a broader implementation. Such a review and analysis would also help identify what strategies supported improved performance, and whether the gains seen reflected changes to clinical care versus increased attention to OASIS completion and accuracy, or to other behavioral changes.

In addition, continuing the program for the originally planned five-year period would allow CMS to better understand how the COVID-19 pandemic has affected HHA operations. Collection of VBP data from periods both before and after the onset of the PHE will provide valuable insights to inform future policy and ways to improve value and outcomes.

We urge CMS to fully evaluate a five-year test period of the HH VBP model and seek additional stakeholder feedback after issuing its final evaluation report, prior to considering a nationwide expansion of the model through future notice and comment rulemaking. A delay in implementation would also provide for additional review and modification of several key program components. CHA offers the following feedback on specific proposed policies:

Payment adjustment
CMS proposes a VBP payment adjustment of +/- 5%. **CHA believes that initiating the VBP program with a 5% payment adjustment is inappropriate. CHA urges CMS to consider a more modest payment adjustment in the first payment year and build to a maximum of 5% in subsequent years.**

The existing HH VBP model started with a payment adjustment of +/- 3 % with plans to increase to a maximum of +/- 8%. Because of the truncated timeframe proposed for the model, we are unable to assess the impact of additional and ongoing payment reductions on HHAs. To be successful, HHAs in non-HH VBP states will need time to understand to understand the data, the VBP methodology, and how it may impact their performance under such a program. **CHA believes that an additional 5% withhold in payments, in addition to previous payment adjustments and reductions experienced by HHAs, could jeopardize their operations and ultimately undermine the success of any VBP program.**

Baseline year
CMS proposes to establish CY 2019 as the baseline year for HHAs certified on or before January 1, 2019. We recognize that this period precedes the pandemic, and that CMS is focusing on this year so as to get a picture of "normal" operations on which to base comparisons. While we agree with this approach in concept, we are concerned that the ongoing nature of the COVID-19 pandemic will make comparisons to pre-COVID-19 operations challenging. Notably, CMS proposes to set a baseline year of CY 2021 — rather than CY 2020 — for HHAs certified during 2019, "out of concern for potential impacts of the COVID-19 PHE on HH quality data." However, the impact of COVID-19 has continued through 2021 and is likely to impact future years.

Each HHA's applicable baseline year would be fixed for all model test years unless changed through rulemaking. Thus, under CMS' current proposal, individual HHAs would be assessed using baselines that reflect very different circumstances and expectations depending on the date of their certification, and those differences will be incorporated into the structure on the program. In other words, the playing field will be uneven — and will be so permanently. **CHA urges CMS to defer implementation of nationwide HH VBP until a full calendar year after the end of the COVID-19 PHE, to allow for adequate data collection and the establishment of a clearly comparable baseline year.**

Cohorts
The original HH VBP model utilizes peer grouping (cohorts) for setting quality measure benchmarks and for making the performance comparisons that determine payment adjustments. Cohort assignment depends in part on HHA service volume; each HHA is assigned to a larger-

volume or smaller-volume cohort within their state based on whether it is required to report HH Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) experience.

CMS now proposes to create two national cohorts, one larger-volume and one smaller-volume, with assignment based on HHCAHPS survey reporting status. This approach produces a larger-volume cohort with 7,084 HHAs and a smaller-volume cohort with 485 HHAs. CMS observes that comparisons within the cohorts would be likely to be internally consistent since most of the smaller-volume cohort members would not be scored on HHCAHPS measures, while larger-volume cohort members would receive HHCAHPS measure scores.

While we appreciate CMS' discussion on this issue, CHA is concerned that moving from state-based to national benchmarks may have unintended consequences for providers. There is wide regional variation in practice patterns, numbers of providers, and access to services; these differences, in turn, are likely to affect an HHA's scores on measures that are included within the total performance score. **For this reason, we suggest that CMS continue to construct cohorts on a state-by-state basis and to collect and analyze performance data to account for regional variations in HHA utilization and performance.**

CHA is also concerned that the use of HHCAPHs as the basis for cohort assignment is inappropriate. For example, some individual HHAs may fall "in" or "out" of the larger volume category from year to year, resulting in uncertainty in cohort assignment and related payment impact. Additionally, we have received some reports that HHAs that meet the HHCAPHS requirement, but have overall fewer admissions/lower census, are at a disadvantage when compared to other HHAs in the larger volume cohort; HHAs with lower patient numbers may have limited ability to demonstrate meaningful changes in performance on selected measures. CHA recommends that CMS consider an alternative factor (e.g., 300 discharges annually) to distinguish between larger and smaller volume agencies for the purpose of cohorting.

Quality Measures
Under the original HH VBP model, participant HHAs were required to report data on three measures, termed "New Measures", for which data submission was not required by HHAs located in states excluded from the model. HHAs were not scored on the New Measures. CMS does not propose to continue the New Measures as part of the expanded HH VBP model test nor to create replacements for the New Measures. **CHA supports this proposal.**

CHA notes that the two claims-based measures in the VBP program — Acute Care Hospital During the First 60 Days of Home Health measure and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health, which are also are included in the HH QRP — are currently proposed for elimination from the QRP and replaced with a single measure: Home Health Within Stay Potentially Preventable Hospitalization (PPH). **CHA urges CMS to align measures in the HH VBP measure set with those in the HH QRP and ensure HHAs have sufficient experience with new measures before including them in the HH VBP.**

Overall, CHA supports the measures that CMS has selected for inclusion in the HH VBP. CHA strongly supports the use of outcomes measures on functional status, such as the two OASIS

composite measures (Total Normalized Composite Change in Mobility and Total Normalized Composite Change Self-Care), as a patient's functional status is inextricably related to their ability to remain in community setting and avoid unnecessary utilization of health care services. In addition, we appreciate that these measures are broadly risk-adjusted to recognize patients with inherently limited goals for improvement, which can help account for differences in patient type that may affect an HHA's performance or certain measures.

However, we urge CMS to consider whether additional risk adjustment would better account for patient differences, specifically for those with more limited potential for functional improvement. While many HH patients are recovering from an acute illness or injury and can be expected to demonstrate increases in mobility and self-care, others with chronic or terminal diagnoses will have a different trajectory. CHA is concerned that if HHAs believe that their overall performance score will be negatively affected by caring for patients with limited potential for functional gain, access to services for certain patient types (e.g., patients who are receiving palliative care) will be limited. Further, HHAs that continue to admit these patient types could be at a disadvantage when compared to others in their VBP cohort.

We urge CMS to ensure measures used in a HH VBP program do not disincentivize HHAs from admitting more medically complex patients, who may be difficult to treat. As compared to free-standing HHAs, HHAs operated by hospitals or health systems often admit and care for more clinically complex patients or patients with greater limitations in other factors affecting outcomes, such as limited access to caregivers or financial insecurity. The performance of agencies that serve such patients may appear significantly different from that of other agencies only because of their patient mix. **CHA urges CMS to carefully evaluate the impact of the HH VBP program on hospital-operated HHAs as part of its overall evaluation of the program before scaling it on a national level.**

NOTICE OF ADMISSIONS

The 2020 HH PPS final rule adopted a requirement that all HHAs submit a "no-pay" Request for Anticipated Payment (RAP) at the beginning of each 30-day period, in order to establish the home health period of care in the common working file and trigger the consolidated billing edits. CMS now proposes that, beginning in 2022, HHAs will submit a one-time Notice of Admission (NOA) that includes similar information to the 2021 RAP. The NOA will establish the home health period of care and covers all contiguous periods of care until the patient is discharged from Medicare home health services. **CHA supports this proposal and appreciates the provision that the NOA will cover all contiguous periods, reducing the administrative burden associated with the current RAP process.**

HH QUALITY REPORTING PROGRAM

Measure Replacement

For CY 2023, CMS proposes to replace two measures — Acute Care Hospital During the First 60 Days of Home Health measure and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health — with the single measure called Home Health Within Stay Potentially Preventable Hospitalization (PPH). The proposed PPH replacement measure reports an HHA-level rate of risk-adjusted potentially preventable hospitalizations or observation stays for Medicare fee-for-service (FFS) beneficiaries that occur within a HH stay for all eligible stays for each HHA. **CHA supports this**

change, and notes that it is consistent with changes implemented in the QRPs for other post-acute care (PAC) settings.

Revised Compliance Date for Certain HH QRP Reporting Measure
CMS proposes to require HHAs to begin reporting two measures — Transfer of Health (TOH) Information to PAC and TOH Information to Patient-PAC — and the elements in the six social determinants of health (SDOH) SPADE data categories beginning January 1, 2023. These measures and SPADEs were initially adopted as HH QRP requirements for CY 2022, but their adoption was subsequently delayed as part of the CMS response to the COVID-19 PHE.

Specifically, in its May 8, 2020, COVID-19 Interim Final Rule with Comment Period (IFC), CMS revised the compliance date for these measures to January 1 of the year that is at least one full calendar year after the end of the COVID-19 PHE. CMS now proposes that the implementation proceed on January 1, 2023, based on the agency's assessment that HHAs are now much better able to report the TOH measures and SDOH SPADEs, and that the PHE has highlighted the need for rapid health information transfer as well as the need to highlight health care disparities that could be identified through the SPADEs. **CHA is concerned that it is premature to revise the compliance date for reporting these measures due to the ongoing COVID-19 PHE and we urge CMS to maintain the implementation timeline as finalized under its May 2020, COVID-19 IFC.**

Our member hospitals and HHAs continue to be significantly challenged by the ongoing COVID-19 pandemic. Throughout California, health care providers at all levels are facing a resurgence of COVID-19 cases and hospital admissions. We expect the PHE to continue at least through the end of this calendar year, and likely into 2022. At the same time, we are beginning to understand some of the long-term disruptions caused by the duration of the pandemic, such as significant reductions in workforce. As providers strive to meet their communities' immediate for both COVID-19 and non-COVID-19-related care, their ability to implement new operational requirements will remain limited.

Implementing these new measures will require HHAs to dedicate significant resources to educating and training staff to use the updated version of the data set, the OASIS-E version, which CMS recognized when it originally delayed implementation. CMS notes that it plans to release a draft of the OASIS-E and associated training education in early 2022. However, CHA is concerned that this timeline does not provide sufficient time for HHAs to operationalize the updated OASIS-E, including training staff and working with vendors to incorporate the updated assessment instrument into their operations, while continuing to respond to the ongoing pandemic.

CHA strongly supports the development and implementation of measures that address SDOH, as is the goal of the SDOH SPADES. We appreciate CMS' current efforts to solicit additional information, including the current request for information (RFI) on Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs, and have submitted comments under separate cover in response to earlier rulemaking. **As CMS seeks to improve and standardize the collection of demographic data to support its efforts in addressing health equity, we urge the agency to allow PAC providers across the continuum sufficient time to operationalize reporting of the SDOH SPADES to ensure the data collected is accurate and comparable across settings. CHA urges CMS to reconsider its proposal to**

revise the compliance date for reporting requirements for the HH QRP, and to return to the timeline established in the May 2020 Interim Final Rule.

CHANGES TO THE CONDITIONS OF PARTICIPATION (COP)

Occupational therapist Initial Assessment

CMS proposes to update the HH CoPs to reflect that an occupational therapist may conduct the initial assessment visit and complete the comprehensive assessment under the Medicare program, but only when occupational therapy (OT) is on the plan of care with either physical therapy (PT) or speech therapy, and as long as skilled-nursing services are not initially on the plan of care. CMS notes that OT alone would not initially establish program eligibility under the Medicare HH benefit. OT can maintain eligibility for Medicare HH care after the need for skilled nursing, PT, and speech language pathology services have ceased. **CHA supports this proposal.**

Home Health Aide Supervision

CMS proposes to make permanent selected regulatory blanket waivers related to the requirements for the supervision of HH aides that were issued to Medicare participating HHAs during the PHE. CMS differentiates aide supervision requirements based on the level of care required by the patient:

- On-site supervisory visits every 14 days are required for aides caring for a patient receiving skilled care from nurses or therapists.
- On-site supervisory visits every 60 days are required for aides caring for a patient who is not receiving skilled care.

CMS also proposes to allow HHAs telecommunication flexibility for the supervisory assessment of the aide service and allow two-way audio-video telecommunications technology that provides interaction between the RN (or other appropriate skilled professional) and the patient. CMS proposes the telecommunications technology cannot exceed two virtual supervisory assessments per HHA in a 60-day period. The home health aide does not need to be present during the supervisory assessment. **CHA supports these proposals and appreciates CMS' efforts to increase appropriate flexibilities to support the delivery of safe patient care.**

REVISED COMPLIANCE DATE FOR CERTAIN REPORTING REQUIREMENTS ADOPTED FOR IRF AND LTCH QRPS

In alignment with its proposal for the HH QRP, CMS proposes to require IRFs and LTCHs to begin reporting two measures — TOH Information to PAC and TOH Information to Patient-PAC — and the elements in the six SDOH SPADE data categories, beginning with FFY 2023, on October 1, 2022. These measures and SPADEs were initially adopted as QRP requirements for the FFY 2022 program, but their adoption was subsequently delayed as part of CMS' effort to decrease provider burden in the face of the COVID-19 PHE. Specifically, as part of its May 8, 2020, COVID-19 IFC, CMS revised the compliance date for the IRF and LTCH QRPs to October 1 of the year that is at least one full fiscal year after the end of the PHE.

As noted in our discussion of the HH QRP, CHA believes that it is premature to revise the compliance date for reporting of these measures due to the ongoing COVID-19 PHE. CHA urges CMS to maintain the implementation timeline as previously finalized under its May 2020 COVID-19 IFC.

Implementing these new measures will require IRFs and LTCHs to dedicate significant resources to educating and training staff on the use of updated versions of their patient assessment instruments, the IRF Patient Assessment Instrument (PAI) assessment tool version (IRF-PAI V4.0) and the LTCH Continuity Assessment Record and Evaluation Data Set (LCDS V5.0). CMS notes that it plans to release drafts of these assessment tools and related education and training in early 2022. CHA is concerned that this aggressive timeline is not realistic as providers across all settings of care continue to be challenged by the COVID-19 PHE. Notably, COVID-19 hospitalization rates have increased significantly since CMS issued its proposed rule. While there is uncertainty on the course of the pandemic over the next several months, the impacts of the PHE are likely to extend into 2022 and it will be difficult for IRFs and LTCHs to operationalize reporting by October 1, 2022. **We urge CMS to maintain its previously finalized implementation timeline of October 1 of the year that is at least one full fiscal year after the PHE to ensure providers have sufficient time to operationalize the updated versions of their respective assessment instruments, including completing any necessary training and ensuring that their vendors can make appropriate programming updates**.

CHA appreciates the opportunity to comment on the HH PPS proposed rule for CY 2022. If you have any questions, please do not hesitate to contact me at mhoward@calhospital.org or (202) 488-3742, or my colleague Pat Blaisdell, vice president, continuum of care, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,
/s/
Megan Howard
Vice President, Federal Policy