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

RE: CMS–1747–P: *Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate 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.*

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 900 hospital-based home health (HH) agencies, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2022 proposed rule for the HH prospective payment system (PPS). Specifically, this letter focuses on the field's behavioral response to the CY 2020 implementation of the new HH PPS case-mix system, the Patient Driven Grouping Model (PDGM), as well as the proposed quality reporting provisions.

We continue to support the PDGM objective of increasing HH PPS payment accuracy. However, we remain concerned that the sizeable behavioral adjustment prospectively implemented in the payment system's first year did not advance this goal. In fact, the field's evaluation identified several specific elements of the adjustment that were erroneously projected, highlighting the historic difficulty CMS has had in aligning prospective adjustments with actual provider behavior. These analyses show that several key CMS behavioral assumptions were inaccurate, as discussed below. In fact, the COVID-19 public health emergency (PHE), which of course could not have been anticipated, underscores the risks inherent in making prospective behavioral offsets. **As such, with regard to any adjustments to the CY 2020 4.36% behavioral offset, we agree with and appreciate CMS' decision to defer action in CY 2022 and ask the**

agency to hold until the conclusion of the PHE. Until then, closer analyses of the gap between projected and actual provider behavior is warranted. In addition, we are interested in better understanding the actual behavioral adjustments made by hospital-based HH agencies, given their unique role, including critical contributions toward pandemic response.

PDGM IMPLEMENTATION AND BEHAVIORAL OFFSET

Given the complexity of the concurrent pressures of PDGM implementation and pandemic response, the AHA appreciates CMS' ongoing monitoring and its decision not to propose any adjustment to the CY 2020 behavioral offset. These pressures have had a significant effect on HH agencies' care delivery, resulting in fewer episodes of care, fewer visits per episode and a greater number of low-utilization payment adjustment (LUPA) visits. Additionally, many agencies reported reductions in non-nursing services, such as visits by therapists, HH aides and social workers, based on patient request or staff limitations. **Such substantial changes underscore the risk inherent in implementing behavioral adjustments in a prospective manner. Indeed, as discussed below, two of CMS' three behavioral assumptions were inaccurate. To use these erroneous assumptions as a basis for modifications to the prior behavioral adjustment would be inappropriate. Therefore, we support CMS' decision to forego proposing changes to its behavioral adjustment and ask the agency to continue to do so until the conclusion of the PHE. We also ask the agency to continue to analyze PDGM implementation trends.** Such analyses should be shared publically and include an examination of the likely short- and long-term utilization and operational shifts that may persist after the PHE, which will assist policymakers and other stakeholders that are beginning to plan for the post-pandemic landscape.

In its proposed rule, CMS estimates that the 2020 30-day episode base payment rate was approximately 6% higher than it would have been under the previous payment system. Because the agency implemented a behavioral adjustment of 4.36%, it states that budget neutrality was not achieved. While the rule did not propose any policies to account for this purported difference, it notes that the law requires CMS to use a combination of permanent and/or temporary adjustments to the HH rate to ensure aggregate spending in CY 2020 neither increased nor decreased under PDGM. Thus, a temporary adjustment would be used to either recoup or repay past over or underspending while a permanent adjustment could be utilized to ensure that future spending neither increased nor decreased relative to payment under the prior policies.

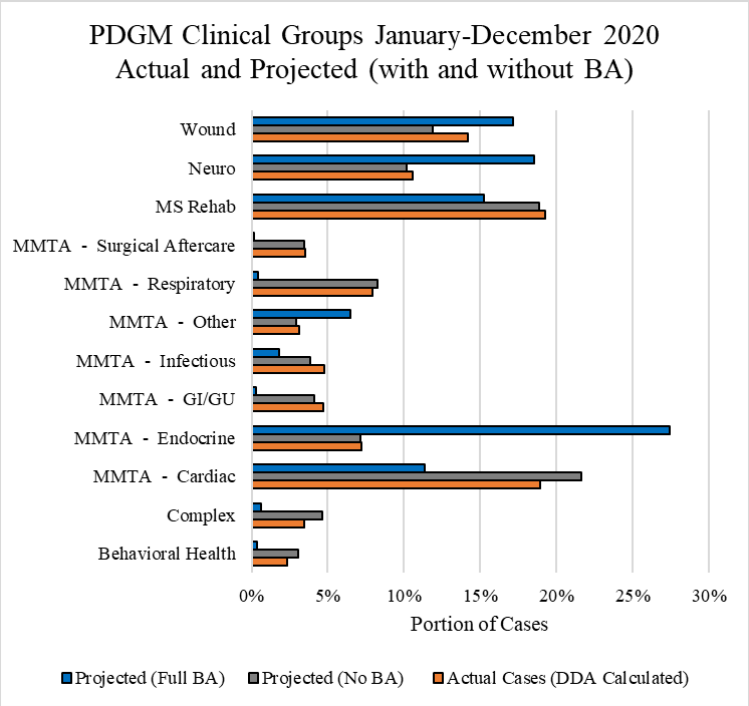
Yet, an analysis commissioned by the Partnership for Quality Home Healthcare identified several substantial concerns with CMS' analysis of budget neutrality, as discussed below. Indeed, when commenting on PDGM implementation, the AHA

and other stakeholders strongly urged the agency to implement a retrospective adjustment based on actual payment data, rather than a prospective adjustment based on projected data. The advantage of a retrospective approach—that it eliminates the often inaccurate assumptions used to project future provider behavior—appears to be substantiated in this case.

- Repricing Methodology Limitations. CMS attempted to reprice the CY 2020 PDGM claims as if they were paid under the prior payment system. However, the CY 2020 claims reflect substantial changes in the payment system, including PDGM's shorter 30-day period and new payment incentives that yielded a major reduction in therapy utilization relative to CY 2019 – an almost 30% drop in therapy visits and a new pattern of service utilization per visit. **We ask CMS to explain how this seeming limitation allows a meaningful comparison between pre-PGDM and PDGM weights and payments. Some analysts believe that this error alone accounts for much of the CMS' finding of CY 2020 overpayment.**

- Behavioral Adjustment Assumptions. **The proposed and final CY 2020 PDGM adjustments were based on three behavioral assumptions, but only one of these projections matches actual behavior, leading us to again question the use of these assumptions, including in adjusting the prior adjustment.**
    - New LUPA Thresholds. CMS made the assumption that to avoid the LUPA[1] per diem rate, one-third of LUPA cases that were otherwise one or two visits away from qualifying for a full HH PPS payment would add visits to acquire a full HH PPS payment. **However, the CY 2020 HH claims show that the rate of LUPA cases as a percent of total cases increased under PDGM, had not decreased as CMS had projected.** Specifically, Medicare claims show that LUPA cases were 8.17% of all cases per month in CY 2020, substantially higher than CMS' predicted rate of 5.3%.
    - Clinical Group Coding. CMS assumed that HH agencies would change their documentation and coding practices to choose the highest-paying diagnosis as the principal diagnosis code. **However, contrary to CMS' projection, coding of principal diagnoses under PDGM generally aligns with prior trends.** As shown in the chart below, the MMTA-Endocrine and Neuro clinical groups closely match historical patterns, when comparing projected trends absent the behavioral adjustment and actual trends.

[1] "LUPA" cases, low-volume episodes of care, receive HH PPS per diem payments. Each of the 432 HH payment units has a unique threshold of visits that determines LUPA status. Under PDGM, CMS projected a drop in the number of LUPA claims, but LUPA frequency rose under PDGM.



Source: Dobson | DaVanzo Analysis of Claims in DUA RIF 54757

- Comorbidity Coding. Since PDGM allows for additional diagnosis codes to be reported, CMS projected that more episodes would qualify for a PDGM comorbidity adjustment. As projected, reported comorbidity levels have increased**. However, while this could be due to a behavioral adjustment by the field, it also could be as a result of an actual increase in aggregate patient acuity due to the PHE.** Indeed, the chart below shows an increase during the PHE in average acuity for all patients discharged from general acute-care hospitals, including patients transferred to HH and the other post-acute settings. These data also show that, in addition to raising acuity levels across the health system, COVID-19 reduced patient volume and increased average length of stay (ALOS). In addition, the data convey the magnitude to which the pandemic continues to dramatically affect the nature of homecare and the overall delivery system. In fact, many anticipate that post-acute care will never fully return to its pre-PHE environment

Referring Hospital Data
(IPPS Discharge Destination Data)
Rate of Change from Pre-PHE to PHE Period*

Referring Hospital Discharge Data	Case Volume	Case-mix Index	Average Length of Stay	Average Number of ICU Days
All Inpatient PPS Discharges	-18.2%	6.9%	8.8%	12.6%
HH	**-6.9%**	**5.0%**	**9.2%**	**10.1%**
SNF	-30.8%	3.2%	8.8%	7.4%
IRF	-11.2%	3.6%	8.4%	6.9%
LTCH	-15.0%	8.5%	15.0%	15.2%

Source: Medicare fee-for-service claims, Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse, https://www2.ccwdata.org/web/guest/home.

*A comparison of the PHE period of Jan. 27, 2020 to Mar. 31, 2021 (approximately 14 months) versus the pre-PHE period of Nov. 23, 2018 to Jan. 26, 2020 (approximately 14 months).

Collectively, these concerns raise serious doubt about the accuracy of both the initial 4.36% PDGM behavioral adjustment and the modified 6% overpayment now estimated by CMS. In order to reliably compare CMS projections versus actual behavior for the first year under PDGM, additional work is warranted.

HH QUALITY REPORTING PROGRAM (QRP)

For the CY 2023 HH QRP, CMS proposes to remove one measure and replace two more with a new measure. In addition, the agency requests feedback on multiple topics, including CMS' efforts to advance health equity and transition to fully digital quality measurement.

The AHA appreciates CMS' ongoing efforts to improve the HH QRP by removing measures that provide little value to patients or providers.

CY 2023 Measurement Proposals

Proposed Removal of Drug Education on All Medications Provided to Patient/Caregiver Measure. CMS proposes to remove this process measure which assesses the percentage of episodes during which the patient/caregiver was provided specific information on the patient's drug therapy, beginning with the CY 2023 HH QRP. We appreciate the agency's rationale that performance on this measure is so high and unvarying across the nation (the mean and median agency

performance scores for this measure in 2019 were 97.1% and 99.2%, respectively) that there is little room for improvement. While the measure addresses the important topic of medication education, the HH QRP contains an outcomes measure, Improvement in Management of Oral Medications, that better and more specifically evaluates whether patients are taking their medications correctly. By removing process measures that can easily become indicators that providers merely "checked a box" in favor of measures that determine whether patients are actually improving, CMS can help providers strive for and achieve better care. **The AHA agrees with CMS' rationale and supports the removal of the Drug Education measure.**

Following the same rationale, CMS should consider removing the Drug Regimen Review Conducted (DRR) measure as well. Like the drug education measure proposed for removal, the DRR measure is also a process measure; it asks providers to attest to two yes or no questions. Also like the drug education measure, national performance is extremely high: according to CMS data updated in late June, the national mean and median performance scores for this measure was approximately 94% and 96%, respectively. The measure was adopted in other post-acute care settings ostensibly to meet the requirements of the Improving Medicare Post-acute Care (IMPACT) Act of 2014's mandate to implement a standardized and interoperable quality measure addressing specific domains including medication reconciliation. However, the DRR measure is a process measure without a validation mechanism, and it is thus difficult to determine that performance on the measure is tied to better patient outcomes. We encourage CMS to consider whether there are other measures available or under development that would better meet the IMPACT Act domain.

Proposed Replacement of Measures with Home Health Within Stay Potentially Preventable Hospitalization Measure. CMS proposes to remove two measures—Emergency Department (ED) Use Without Hospitalization During the First 60 Days of Home Health and Acute Care Hospitalization During the First 60 Days of Home Health—and simultaneously adopt a new measure, Home Health Within Stay Potentially Preventable Hospitalization (PPH). We agree that the measures proposed for removal may not provide accurate assessments of provider performance or actionable information. HH providers may be unable to prevent ED visits due to factors outside of their control, including geographic factors like a lack of alternative (and lower intensity) sites of care or patient-level factors, such as a lack of family or community support. In addition, it is difficult to determine appropriate attribution for hospitalization between different providers and settings, especially because the current all-cause hospitalization measure does not require the reason for admission to be related to the reason the patient is receiving home health care. By removing these two measures in favor of one that is more likely to reflect whether HH agencies are providing proper management and care as well as clear discharge instructions and referrals, CMS can better assess quality of care and report useful information to

consumers. **Thus, we support removal of both the ED Use and Hospitalization During the First 60 Days of Home Health measures.**

However, before we can support adoption of the PPH measure in their place, we urge CMS to address two concerns. First, the PPH measure uses the Agency for Healthcare Research & Quality's Prevention Quality Indicators and Ambulatory Care Sensitive Conditions to inform the definition for hospitalizations that can be potentially prevented. These frameworks are not specific to post-acute care or to hospitalization, and home health care generally is not included in the definition of ambulatory care. While CMS shares its analyses that applied the conceptual definition of potentially preventable hospitalization to claims data, we encourage the agency to continue to monitor performance and hone this definition with the help of stakeholders and quality improvement experts.

Second, we recommend that CMS incorporate social determinants of health (SDOH) into its risk adjustment methodology. As proposed, the PPH measure is risk-adjusted for demographics including age, sex, enrollment status and activities of daily living scores, but not other SDOH that have a demonstrated impact on hospitalization. Several reports, including from the National Academies of Medicine, have shown that there are a number of plausible mechanisms by which sociodemographic information can be incorporated meaningfully into quality measurement. **We urge CMS to incorporate social risk factors into the risk adjustment for the PPH measure and submit the measure for review by the National Quality Form before its adoption.**

Updated Reporting Timeline for Measures and Standardized Patient Assessment Data Elements (SPADEs). In the CY/fiscal year (FY) 2020 final rules for HH, inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs), CMS adopted two new quality measures and several SPADEs. The quality measures, Transfer of Health Information (TOH) to the Patient and TOH to the Provider, and the SPADEs (including seven elements regarding SDOH) were originally scheduled for implementation on Jan. 1, 2021 for HH agencies and Oct. 1, 2020 for IRFs and LTCHs. However, in light of the challenges associated with the PHE, CMS issued an interim final rule in May 2020 that delayed the compliance date for reporting these measures and SPADEs until Jan. 1 (for HH agencies) and Oct. 1 (for IRFs and LTCHs) of the year that is at least one full calendar year after the end of the PHE. In turn, CMS delayed the releases of the updated versions of the patient assessment instruments for which providers would report the measures and SPADEs. In the CY 2022 HH proposed rule, however, CMS asserts that it now believes post-acute care providers are able to begin reporting for these measures and SPADEs sooner than established in the interim final rule, and proposes to require data collection using the updated versions of the patient assessment instruments beginning Jan. 1, 2023 for HH agencies and Oct. 1, 2022 for IRFs and LTCHs.

The AHA urges CMS not to adopt this proposal but instead retain the reporting deadlines adopted in last year's interim final rule. We disagree with CMS' assertion that the flexibilities and assistance granted by the agency during the PHE as well as the promising trends in COVID-19 vaccination and death rates cited in the rule have left providers "in a better position to accommodate reporting of the TOH measures and certain (Social Determination *(sic)* of Health) Standardized Patient Assessment Data Elements." While CMS suggests that post-acute care providers "now have the administrative capacity to attend training, train their staff, and work with vendors to incorporate the updated assessment instruments into their workflows," the reality is that providers continue to struggle in the midst of an unprecedented and ongoing pandemic. In addition to caring for their regular patients, some IRFs and LTCHs have been converting their beds to take on overflow from the intensive care units of general acute care hospitals and treating patients with long-term and acute COVID-19 symptoms; high-acuity, functionally impaired COVID-19 patients are medically complex, many requiring ventilators, dialysis or wound care due to the disease process or long stays in the ICU. The additional costs of preparing for and treating COVID-19 patients—including but not limited to personal protective equipment, respiratory systems, medications and facility infrastructure changes to house additional patients—have taken priority over training staff to complete patient assessment tasks, many of which have questionable relevance and value, as we have noted in prior comment letters.

Part of CMS' rationale behind hastening the reporting of the recently finalized SPADEs is that implementing the elements under the newest domain of social determinants of health could increase the amount of data related to important social risk factors. We understand the importance of collecting, analyzing and using this data. However, CMS also issued several requests for information (RFIs) in the various CY and FY 2022 proposed rules asking for feedback on potentially creating standardized data collection elements across the entire continuum of care, not just post-acute care. It would create confusion and unnecessary administrative burden for CMS to hurriedly add data elements to the post-acute patient assessment tools because they happen to be available now, only to replace them with more reliable elements and strategies based on the feedback gleaned from the RFIs as well as CMS' other ongoing work on its Disparity Methods.

In addition, the updated versions of the patient assessment instruments with the new measures and SPADEs—the OASIS-E for HH agencies, IRF Patient Assessment Instrument (PAI) V.4.0 for IRFs, and LTCH CARE Data Set (LCDS) V.5.0 for LTCHs—are not yet available. CMS proposes in this rule that it would release a draft of these updated versions "in early 2022." Considering current trends in disease incidence due to the ubiquity of the delta variant of the COVID-19 virus as well as the extension of the national PHE for COVID-19, it is possible that post-acute care

providers might still be working under the constraints of the pandemic in early 2022. Thus, **we urge CMS to maintain the timeline for reporting of the new measures and SPADEs established in the May 2020 interim final rule.**

HH Value-Based Purchasing (VBP) Program Proposals

Invoking its authority under the Affordable Care Act to test payment models intended to improve quality and/or reduce cost, CMS launched a HH VBP on Jan. 1, 2016; this model was planned for five program years. Participation in the HH VBP is mandatory for all CMS-certified HH agencies in nine states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington. HH agencies in these states are subject to upward and downward payment adjustments starting with a maximum of 3% in the first program year (2018) to 8% in the fifth program year (2022) based on performance on selected measures. The scoring approach recognizes HH agencies for both their level of achievement compared to national benchmarks as well as improvement compared their own previous performance.

In this rule, CMS proposes to expand the model to a national, mandatory program starting Jan. 1, 2022 (i.e., performance in CY 2022 would inform the preliminary payment adjustment on CY 2024 payments).

The AHA continues to support the concept of a HH VBP. We agree that a mix of public quality reporting and pay-for-performance measures can align the health care delivery system—including HH providers—toward continuous quality improvement and reward providers for excellence. We also support several design aspects of the current HH VBP model, including rewarding the better of achievement or improvement and implementing the program in a budget-neutral fashion. **However, we do not agree that CMS should end the current model early and expand the program to a national, mandatory model starting Jan. 1, 2022.** It is clear that CMS is in a hurry to implement the HH VBP model nationwide; it is less clear why the agency is acting so hastily in light of current evidence.

The data provided by CMS in the proposed rule and the evaluation reports do not demonstrate that the HH VBP model is worthy of or ready for national expansion. It has not led to a significant improvement in quality of care or reduction in spending. According to the Fourth Annual Report, the first *four years* of the model resulted in a cumulative 1.3% reduction in Medicare spending in the states participating in the HH VBP compared to non-HHVBP states, and mixed impact on utilization. That is, there were decreases in utilization of some services and increases in utilization of others. Quality of care among HH agencies in HH VBP states also shows a mixed picture. Total performance scores (TPS) were 8% higher than in non-HH VBP states. Yet, some quality measures, including on patient experience, actually saw a decrease in performance. TPS did not improve uniformly across all four program years; only five out of the nine states in the current model had higher average TPS scores than their

respective regional comparison groups (i.e., nearby and comparable states not participating in the HH VBP) in most recent program year, and two actually had lower scores than their regional counterparts.

The cumulative results of the model suggest positive, if middling, results, but individual HH agencies and their patients saw little change due to the HH VBP model. According to the same annual report, "few reported experiencing a noticeable impact from the model's financial incentives…those with negative perspectives of the model often observed that the increase in documentation and reporting efforts did not yield a corresponding improvement in care delivery or financial reward commensurate with the agency's effort." Agencies interviewed for the annual report pointed to multiple drivers of operational changes other than the HH VBP, including Medicare Conditions of Participation, changing OASIS documentation requirements and avoidable readmission programs. Thus, even for agencies that did improve their performance, it would be difficult to attribute progress solely to the HH VBP model.

This is not to say that the HH VBP model was a failure; rather, these unexceptional returns weaken CMS' proposal to expand the model *immediately*. The HH VBP model is complex, and implementing it in 41 new states is an operationally complex undertaking to complete in about three months (after the CY 2022 HH PPS final rule is issued). In addition, CMS proposes in this rule to remove two measures, which contribute 35% of the total performance score, from the HH QRP and seeks comment on whether the agency should remove them from the HH VBP program as well; we believe the agency should remove the measures outright, but this would also completely alter the already complex scoring methodology for the HH VBP. Finally, we have not yet determined the longer term effects of the ongoing COVID-19 PHE on HH care. If CMS ends the HH VBP model early, as it proposes, we will not get the opportunity to analyze how the model interacts with these effects. In other words, if CMS wants to expand the HH VBP model in a post-COVID world, one likely to be permanently altered with serious implications for non-facility-based care, shouldn't the agency test the model in that world first?

Therefore, we encourage CMS to continue the HH VBP model in the nine states in which it is currently operating as originally established for the final performance year rather than end this model early and expand the HH VBP nationally starting on Jan. 1, 2022.

Requests for Information

Health Equity. In light of the Administration's efforts to address equity—specifically health equity—the agency requests information on revising several CMS programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for providers and patients. Specifically, the agency seeks recommendations for quality measures or measurement domains

that address health equity as well as the collection of other SPADEs that address gaps in health equity in post-acute care quality reporting programs.

The AHA applauds CMS' focus on addressing disparities in health outcomes by thoughtfully considering how to best leverage data; we agree providing equitable care begins with understanding the unique needs of patients. Data and analytics allow providers to see the barriers some patients may face when accessing care; help pinpoint where to deploy resources to address gaps in access or quality of care; and provide deeper insights to inform intentional actions by leadership and clinical teams. Because of this, the AHA and its Institute for Diversity and Health Equity recently launched the first in a new series of toolkits designed to help hospitals and health systems make progress in advancing their health equity agendas. This toolkit, Data-Driven Care Delivery: Data Collection, Stratification and Use, addresses the importance of segmenting and leveraging patient data to tackle disparate care outcomes and drive improvements. We welcome the opportunity to work closely with CMS and the entire Biden Administration to develop best practices based on our members experiences.

As CMS develops its quality measurement approach to health equity, we encourage the agency to strive for consistency and alignment. One way to do this is to consider data collection across the continuum of care. In the FY 2020 proposed rules for the LTCH, IRF, SNF and HH prospective payment systems, CMS adopted seven SPADEs addressing SDOH. In our comments on those rules, we requested clarity on the potential future uses of these elements and the requirements around data collection for certain elements, such as the frequency with which those SPADEs are collected. In addition, we were unsure that the response options under the Race data element were the right ones. It appears that some of the categories are not consistent with those used in other government data collection practices, like the U.S. census or the Office of Management and Budget, or with the recommendations made in the 2009 Institute of Medicine report on Standardized Collection of Data on Race, Ethnicity and Language. Considering that health is affected by factors and circumstances not only adjudicated under the Department of Health and Human Services, it is vital that CMS work closely with other agencies and government actors to ensure that we are all collecting the same—and the right—data in the same—and the right—way.

Further, regarding CMS' request for feedback on additional SDOH SPADEs, we urge the agency to gain more operational experience with these seven newly added elements before adopting additional data fields. These elements have not been in use for an entire year, so the feasibility and usefulness of the information gleaned from their use remains to be seen. As in the rest of its quality measurement enterprise, CMS should strive for a streamlined and parsimonious set of data

elements to increase the likelihood of collecting precise information in the most efficient way possible.

Finally, many of CMS' suggestions, programs and proposals regarding disparities are defined around either race and ethnicity or dual eligibility for Medicare and Medicaid as a proxy for income. While these factors are doubtless vital to assess, the agency—and providers—need to explore other demographic and social risk factors as well. These include, but are not limited to, sexual orientation, gender expression, education and literacy, veteran status, disability status, housing, social isolation and community resources.

Digital Quality Measures (dQMs) and Fast Healthcare Interoperability Resource (FHIR). In this rule, CMS outlines the agency's general considerations for the future development and staged implementation of a cohesive portfolio of dQMs across quality programs, agencies and private payers, as well as the potential use of FHIR for dQMs within quality programs. The AHA agrees that a digital and interoperable quality enterprise is a laudable goal that could have positive and far-reaching effects of patient outcomes and experience. We also support the potential use of FHIR, as this standard is easier to implement and more fluid than many other available frameworks. **However, we encourage CMS to hone its approach to transforming its quality measurement enterprise by more clearly defining the goals and expectations for providers and considering the specific needs and capabilities of post-acute care providers and their patients.**

The seminal statute for health information technology (HIT), the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, resolved to spend $25.9 billion to promote and expand the adoption of health IT. To implement the requirements of the HITECH Act, CMS offered incentives to eligible professionals and hospitals that adopt and demonstrate the meaningful use of electronic health records (EHRs). However, long-term care and post-acute care providers were not eligible for the EHR Incentive Programs (now known as the Promoting Interoperability Programs) under the Act. In its 2019 RFI that accompanied the Interoperability and Patient Access proposed rule, CMS largely attributed the slow rate of EHR adoption in post-acute care settings to the lack of federal incentives available to these providers.

In addition to this lag, the experience with various HIT capabilities in post-acute care is heterogeneous; while some providers have been able to successfully incorporate HIT with higher levels of sophistication, including certified EHR technology (CEHRT), others are using technologies with fewer capabilities for digital exchange. The shortages in HIT professionals and resources dedicated to HIT are particularly dire for post-acute care providers, so any new requirements for attestation to digital

capabilities will result in even more competition for vendor attention—both among post-acute care providers and between post-acute and general acute care providers.

Because of these challenges, any approach to digital quality measurement in post-acute care will have to be nuanced and gradual. We encourage CMS to consider developing a "glide path" for post-acute care provider participation in digital quality measurement, one that provides technical assistance for providers who are less advanced in their HIT capabilities as well as more opportunities for achievement for those who are well on their way. **Adoption and implementation of HIT systems like CEHRT is not like flipping a switch; it involves painstaking and thoughtful groundwork to establish an infrastructure—including security and personnel as well as physical investments—that can support highly technical requirements.** A definition of dQMs must be understandable for those providers who do not have as robust a technology infrastructure so that they can work to someday achieve interoperability rather than abandon hope because the future is daunting and expensive.

We encourage CMS to further hone its definition of dQMs by setting clear and specific parameters for what the agency hopes to achieve and what it expects of participating providers. For example, what would the agency do differently to "transform" its quality measurement enterprise in order for the measures used in various quality reporting programs to meet the definition of dQMs? The definition proffered in the RFI is quite broad, and lists data sources including "administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated health data), health information exchanges (HIEs) or registries, and other sources." Using this definition, it could be argued that SNFs, LTCHs, IRFs, and HHAs are already reporting dQMs, and thus no "transformation" is necessary. On the other hand, it could also be argued that the agency, in seeking to fully transition to dQMs by 2025, expects providers to be able to interact with all of these data sources and thus take on more than a decade's worth of un-funded work in just a few years.

In order to plan for the future of digital quality measurement, CMS should more clearly define what it expects that future to look like for all providers, specifically post-acute care providers, and how those expectations differ from the status quo. The AHA and our members are excited to work with CMS to build their digital quality measurement enterprise, and we would be happy to collaborate on more specific plans for the future.

We thank you for the opportunity to comment on this proposed rule. If you have any questions concerning our comments, please feel free to contact me, or have a member of your team contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org regarding the payment provisions, or Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org regarding the quality and home infusion therapy provisions.

Sincerely,

/s/

Stacey Hughes
Executive Vice President