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WASHINGTON perspectives

An Analysis and Commentary on Federal Health Care Issues
by Larry Goldberg

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CMS Finalizes Calendar Year 2022 Home Health Prospective Payment System Update

The Centers for Medicare and Medicaid Services (CMS) have issued a final calendar year (CY) 2022 update to the home health prospective payment system (HH PPS).

The 528-page rule is currently on display at the ***Federal Register.*** A copy is available at: https://public-inspection.federalregister.gov/2021-23993.pdf. Publication is slated for November 9. This link will change upon publication. The rule and its changes are effective January 1, 2022.

The rule updates the payment rates for home health agencies (HHAs), finalizes the recalibration of the case-mix weights for 30-day periods of care while maintaining the CY 2021 low utilization payment adjustment (LUPA) thresholds, updates the CY 2022 fixed-dollar loss ratio (FDL), uses the physical therapy (PT) add-on factor to establish the occupational therapy (OT) LUPA, and updates the home infusion therapy services payment rates.

Additionally, the rule expands the Home Health Value-Based Purchasing (HHVBP) Model to all Medicare-certified HHAs in the 50 States, Territories, and the District of Columbia beginning January 1, 2022 with CY 2022 as a pre-implementation year, and ending the original HHVBP Model one year early for the HHAs in the nine original Model States, such that CY 2020 performance data would not be used to calculate a payment adjustment for CY 2022.

Further, the rule finalizes proposals under the HH Quality Reporting Program (QRP), including removal of an Outcome and Assessment Information Set (OASIS)-based measure, the Drug Education on All Medications Provided to Patient/Caregiver During All Episodes of Care measure, replaces the Acute Care Hospitalization During the First 60 Days of Home Health (NQF #0171) measure and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (NQF #0173) measure with the Home Health Within Stay Potentially Preventable measure, and will begin public reporting of the Percent of Residents Experiencing One or More Major Falls with Injury measure and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) measure beginning in April 2022.

The rule also makes permanent the changes to the home health Conditions of Participation (CoP) that were implemented during the COVID-19 public health emergency (PHE) and finalizes changes to the CoPs to implement a provision of the ***Consolidated Appropriations Act***, 2021.

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larry004b@gmail.com

Comments

CMS says that the provisions in this final rule will result in an estimated net increase in home health payments of 3.2 percent for CY 2022 ($570 million). The $570 million increase in estimated payments reflects the effects of the CY 2022 home health payment update percentage of 2.6 percent ($465 million increase), a 0.7 percent increase in payments due to a new lower FDL ratio, which will increase outlier payments in order to target to pay no more than 2.5 percent of total payments as outlier payments ($125 million increase) and an estimated 0.1 percent decrease in payments due to the rural add-on percentages mandated by the ***Bipartisan Budget Act of 2018*** for CY 2022 ($20 million decrease).

CMS provides the following table regarding costs, transfers, and benefits. The material is copied directly from the rule. Therefore, any reference to "our," or "we" refer to CMS.

Summary of Costs, Transfers, and Benefits

Provision Description	Costs and Cost Savings	Transfers	Benefits
CY 2022 HH PPS Payment Rate Update		The overall economic impact of the HH PPS payment rate update is an estimated $570 million (3.2 percent) in increased payments to HHAs in CY 2022.	To ensure home health payments are consistent with statutory payment authority for CY 2022.
HHVBP		The overall economic impact of the expanded HHVBP Model for CYs 2023 through 2027 is an estimated $3.376 billion in total savings to FFS Medicare from a reduction in unnecessary hospitalizations and skilled nursing facility (SNF) usage as a result of greater quality improvements in the HH industry. As for payments to HHAs, there are no aggregate increases or decreases expected to be applied to the HHAs competing in the model.	
HH QRP	The total savings beginning in CY 2023 is an estimated $2,762,277 based upon the removal of one OASIS-based measure, item M2016.		
Changes to the Home Health Conditions of Participation	We do not anticipate any costs or cost savings associated with our proposed Conditions of Participation provisions.		
Medicare Coverage of Home Infusion Therapy		The overall economic impact of the statutorily-required HIT payment rate updates is an estimated increase in payments to HIT suppliers of 5.1 percent($300,000) for CY 2022.	To ensure that payment for home infusion therapy services are consistent with statutory authority for CY 2022.
Provider and Supplier Enrollment Processes	We do not anticipate any costs or cost savings associated with our Medicare provider and supplier enrollment provisions.	The overall impact of our provider enrollment provisions will be a transfer of $54,145,000 from providers/ suppliers to the Federal Government. This will result from our provision prohibiting payment for services and items furnished by a deactivated provider or supplier.	

Provision Description	Costs and Cost Savings	Transfers	Benefits
Survey and Enforcement Requirements for Hospice Programs	We estimate that the provisions that we present in the preamble of this final rule to implement Division CC, section 407 of CAA 2021 will result in an estimated cost of approximately $5.5 million from FY 2021 through FY 2022.	We do not anticipate any transfers associated with our Medicare survey and enforcement requirements for hospice programs.	To ensure a comprehensive strategy to enhance the hospice program survey process, increase accountability for hospice programs, and provide increased transparency to the public.
COVID-19 Reporting Requirements for Long Term Care Facilities	The total estimated continuing cost for the LTC reporting requirements finalized in this rule is $2,171,571.		These changes will extend the benefits of COVID-19 reporting for LTC facilities beyond the PHE and will provide LTC facilities with more flexibility and eliminate unnecessary burden.

CMS seems to be increasing the size of total payment amounts to provider categories by including prior year outlier underpayments in developing future year outlier threshold values. True, CMS modifies current thresholds to try and bring current outliers payments in line with its policy objectives. For HHA this amount is 2.5 percent. Nonetheless, prior year underpayments are not being made as suggested. This policy appears highly deceptive. Again, there is an urgent need to update CMS' outlier policies.

The size of Medicare savings resulting from the expanded HHVBP model is explosive at $3.376 billion over the next 5 years. Is the program truly improving quality or simply reducing provider payments?

CY 2022 Home Health Payment Rate Updates

Market Basket

Based on IHS Global Inc.'s (IGI's) third quarter 2021 forecast, the CY 2022 increase in the 2016-based home health market basket is 3.1 percent (compared to the proposed rule of 2.4 percent), which is "primarily due to forecasted higher compensation prices."

The 3.1 percent is reduced by a productivity adjustment, as mandated by the ***Affordable Care Act*** (ACA) currently estimated to be 0.5 percentage points for CY 2022. In effect, the home health payment update percentage for CY 2022 is 2.6 percent.

For HHAs that do not submit the required quality data for CY 2022, the home health payment update is 0.6 percent (2.6 percent minus 2.0 percentage points).

The labor share will be 76.1 percent and the non-labor share would be 23.9 percent, same as the current rates.

Comment

As we noted in our analysis of the recently released final CY 2022 ESRD PPS update, CMS has always made market-basket and productivity adjustments between its proposed and final update rules.

Perhaps it's time for CMS to account for changes in the market-basket between its final update and what transpires during the year.

CY 2021 Home Health Wage Index

CMS is finalizing its proposal to continue to use the pre-floor, pre-reclassified hospital inpatient wage index with no 5.0 percent cap on wage index decreases as the wage adjustment to the labor portion of the HH PPS rates. For CY 2022, the updated wage data are for the hospital cost reporting periods beginning on or after October 1, 2017 and before October 1, 2018 (FY 2018 cost report data).

The final CY 2022 HH PPS wage index is available on the CMS website at: https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.

Recalibration of Patient-Driven Groupings Model (PDGM) Case-Mix Weights

Each of the 432 payment groups under the PDGM has an associated case-mix weight and low utilization payment adjustment (LUPA) threshold. CMS' policy is to annually recalibrate the case-mix weights using the most complete utilization data available at the time of rulemaking. CMS is finalizing the recalibration of the PDGM case-mix weights, functional levels, and comorbidity adjustment subgroups while maintaining the CY 2021 LUPA thresholds for CY 2022.

These are being reported in a separate ***Washington Perspectives***.

Comment

CMS is also making a number of changes regarding requested disease and disorders for a clinical group or comorbidity subgroup reassignment. Refer to the rule for more detailed information.

Occupational Therapy LUPA Add-on Factor

Division CC, Section 115, of the ***Consolidated Appropriations Act***, 2021 (CAA 2021) included provisions to allow Occupation Therapists (OTs) to conduct initial and comprehensive assessments for all Medicare beneficiaries under the home health benefit when the plan of care does not initially include skilled nursing care, but includes either Physical Therapy (PT) or Speech-Language Pathology (SLP).

CMS is finalizing conforming regulation text changes for this provision. Since OTs can now conduct the initial and comprehensive assessments, CMS is establishing a LUPA add-on factor for the first skilled occupational therapy visit in LUPA periods that occurs as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care. Currently, CMS notes that there is insufficient data regarding the average excess of minutes for the first visit in LUPA periods when the initial and comprehensive assessments are conducted by OTs.

Therefore, CMS will utilize the physical therapy LUPA add-on factor as a proxy until CY 2022 data is available to establish a more accurate occupational therapy add-on factor for the LUPA add-on payment amounts.

CY 2022 National, Standardized 30-Day Period Payment Amount

The CY 2022 national standardized 30-day episode payment rate will be as follows.

CY 2021 National Standardized 30-day Period Payment	Case-MIX Weights Recalibration Neutrality Factor	Wage Index Budget Neutrality Factor	CY 2022 HH Payment Update	CY 2022 National, Standardized 30-Day Period Payment
$1,901.12	1.0396	X 1.0019	X 1.026	$2,031.64

The CY 2022 30-day national standardized 30-day episode payment amount for HHAs that DO NOT submit quality data is as follows.

CY 2021 National Standardized 30-day Period Payment	Case-MIX Weights Recalibration Neutrality Factor	Wage Index Budget Neutrality Factor	CY 2022 HH Payment Update Minus 2.0 Percent	CY 2022 National, Standardized 30-Day Period Payment
$1,901.12	1.0396	X 1.0019	X 1.006	$1,992.04

CY 2022 National Per-Visit Payment Amounts Rates

The CY 2022 national per-visit rates for HHAs that submit required quality data are updated by the CY 2022 HH payment update percentage of 2.6 percent and are shown in the table below.

CY 2022 National Per-Visit Payment Amounts

HH Discipline	CY 2021 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2022 HH Payment Update	CY 2022 Per-Visit Payment
Home Health Aide	$69.11	X 1.0019	X 1.026	$71.04
Medical Social Services	$244.64	X 1.0019	X 1.026	$251.48
Occupational Therapy	$167.98	X 1.0019	X 1.026	$172.67
Physical Therapy	$166.83	X 1.0019	X 1.026	$171.49
Skilled Nursing	$152.63	X 1.0019	X 1.026	$156.90
Speech-Language Pathology	$181.34	X 1.0019	X 1.026	$182.77

Rural Add-On Payments for CY 2022

Section 50208(a)(1)(D) of the ***Balanced Budget Act*** (BBA) of 2018 added a new subsection (b) to section 421 of the ***Medicare Modernization Act*** to provide rural add-on payments for episodes or visits ending during CYs 2019 through 2022.

It also mandated implementation of a new methodology for applying those payments. Unlike previous rural add-ons, which were applied to all rural areas uniformly, the extension provided varying add-on amounts depending on the rural county (or equivalent area) classification by classifying each rural county (or equivalent area) into one of three distinct categories: (1) rural counties and equivalent areas in the highest quartile of all counties and equivalent areas based on the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under Part A of Medicare or enrolled for benefits under Part B of Medicare only, but not enrolled in a Medicare Advantage plan under Part C of Medicare (the "High utilization" category); (2) rural counties and equivalent areas with a population density of 6 individuals or fewer per square mile of land area and are not included in the ''High utilization'' category (the ''Low population density'' category); and (3) rural counties and equivalent areas not in either the ''High utilization'' or ''Low population density'' categories (the ''All other'' category).

The CY 2020 through 2022 rural add-on percentages outlined in law are shown below.

Category	CY 2020	CY 2021	CY 2022
High utilization	0.5%	None	None
Low population density	3.0%	2.0%	1.0%
All other	2.0%	1.0%	None

Payments for High-Cost Outliers under the HH PPS

CMS is adopting a Fixed Dollar Loss (FDL) ratio of 0.40 for CY 2022. This is a decrease from the current FDL ratio of 0.56.

Home Health Value-Based Purchasing (HHVBP) Model

CMS, as proposed, is expanding the Home Health Value-Based Purchasing (HHVBP) Model to all Medicare-certified HHAs in the 50 States, territories, and District of Columbia beginning January 1, 2022 with CY 2022 as the first performance year and CY 2024 as the first payment year, based on HHA performance in CY 2022. The rule will also end the original HHVBP Model one year early for the HHAs in the nine original Model States (Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington), such that CY 2020 performance data would not be used to calculate a payment adjustment for CY 2022.

Defining Cohorts for Benchmarking and Competition

CMS says "a key consideration in defining the cohorts is ensuring sufficient HHA counts within each cohort."

CMS is finalizing the use of national, volume-based cohorts in setting payment adjustments under the expanded Model, as proposed, and CMS is also finalizing to codify this policy at §484.370.

Payment Adjustment

The start of payment adjustments under the expanded Model will begin with CY 2025, with payment adjustments based on performance in CY 2023.

Baseline Year

CMS is finalizing its proposal to use CY 2019 (January 1, 2019 through December 31, 2019) as the baseline year.

Comment

There is much more to this item than the information cited above. The material spans some 124 pages and as such requires an in-depth review. Subjects include scoring, benchmarking, and achievement. This is probably the most complex aspect of the rule.

Home Health Quality Reporting Program (HH QRP)

The HH QRP currently includes 20 measures for the CY 2022 program year.

CMS is removing the Drug Education on all Medications Provided to Patient/Caregiver measure. HHAs will no longer be required to submit OASIS Item M2016, Patient/Caregiver Drug Education Intervention for the purposes of this measure beginning January 1, 2023.
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CMS is finalizing the replacement of the Acute Care Hospital During the First 60 Days of Home Health (NQF #0171) measure and the Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (NQF #0173). A measure that is more strongly associated with desired patient outcomes for the particular topic is available, with the Home Health Within Stay Potentially Preventable Hospitalization Measure beginning with the CY 2023 HH QRP.

Schedule for Publicly Reporting Quality Measures Beginning with the CY 2022 HH QRP

CMS is finalizing its proposal to publicly report the Percent of Residents Experiencing One or More Major Falls with Injury measure and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) measure beginning in April 2022.

Collection of the Transfer of Health Information to Provider-PAC measure, the Transfer of Health Information to Patient-PAC measure, and Certain Standardized Patient Assessment Data Elements Beginning January 1, 2023

HHAs will collect the Transfer of Health Information to Provider Post-Acute Care measure, the Transfer of Health Information to Patient-PAC measure, and certain Standardized Patient Assessment Data Elements beginning January 1, 2023. HHAs will begin collecting data on the two TOH measures beginning with discharges and transfers on January 1, 2023 on the OASIS-E. "We are also finalizing that HHAs will collect data on the six categories of Standardized Patient Assessment Data Elements on the OASIS-E, with the start of care, resumption of care, and discharges (except for the hearing, vision, race, and ethnicity Standardized Patient Assessment Data Elements, which would be collected at the start of care only) beginning on January 1, 2023."

Changes to the Home Health Conditions of Participation

CMS is finalizing its proposed 14-day aide supervisor visit at § 484.80(h)(1) with modification. CMS will permit one virtual supervisory visit via interactive telecommunications systems per patient per 60-day episode. This visit must only be done in rare instances for circumstances outside the HHA's control and must have documentation in the medical record detailing such circumstances. At § 484.80(h)(2) CMS is modifying the semi-annual onsite visit to require that this visit be conducted on "each" patient the aide is providing services to rather than "a" patient.

Permitting Occupational Therapists to Conduct the Initial Assessment Visit and Complete the Comprehensive Assessment for Home Health Agencies Under the Medicare Program

Division CC, section 115 of the CAA 2021 requires CMS to permit an occupational therapist to conduct the initial assessment visit and complete the comprehensive assessment under the Medicare program, but only when occupational therapy is on the home health plan of care with either physical therapy or speech therapy and skilled nursing services are not initially on the plan of care. CMS has adopted its proposal as proposed.

Home Infusion Therapy Services: Annual Payment Updates for CY 2022

The Medicare home infusion therapy services benefit covers the professional services, including nursing services, furnished in accordance with the plan of care, patient training and education not otherwise covered under the durable medical equipment benefit, remote monitoring, and monitoring services for the provision of home infusion therapy furnished by a qualified home infusion therapy supplier.

Home Infusion Payment Categories

There are 3 payment category group home infusion drugs by J-code based on therapy type. Payment category 1 comprises certain intravenous infusion drugs for therapy, prophylaxis, or diagnosis, including antifungals and antivirals; inotropic and pulmonary hypertension drugs; pain management drugs; and chelation drugs. Payment category 2 comprises subcutaneous infusions for therapy or prophylaxis, including certain subcutaneous immunotherapy infusions. Payment category 3 comprises intravenous chemotherapy infusions and other highly complex intravenous infusions. CMS has not made any changes to the three payment categories for CY 2022.The categories and associated J-codes can be

found in the MLN Matters article entitled "Billing for Home Infusion Therapy Services on or After January 1, 2021" (MM11880).

Payment Adjustment

CMS will apply a Geographic Adjustment Factor (GAF) budget neutrality factor to home infusion therapy payments whenever there are changes to the GAFs in order to eliminate the aggregate effect of variations in the GAFs. The CY 2022 GAF standardization factor that will be used in updating the payment amounts for CY 2022 will be 1.0001. The final CY 2022 GAF values will be posted as an addendum on the Physician Fee Schedule website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched under the supporting documentation section of the CY 2022 Medicare Physician Fee Schedule Final Rule and posted on the Home Infusion Therapy Billing and Rates webpage.

CY 2022 Payment Amounts

The consumer price index for all urban consumers (CPI-U) for the 12-month period ending in June of 2021 is 5.4 percent and the corresponding productivity adjustment is 0.3 percent. Therefore, the final home infusion therapy payment rate update for CY 2022 is 5.1 percent.

Final CY 2022 National Home Infusion Therapy (HIT) Services 5-Hour Payment Amounts

HCPCS	Description	CY 2021 National Unadjusted Payment Rates	GAF Standardization Factor	CPI-U Reduced by Productivity Adjustment	Final 2022 HIT Payment Amount
G0068	Adm iv infusion drug in home	$154.39	X 1.0001	X 1.0510	$162.28
G0069	Adm sq infusion drug in home	$208.61	X 1.0001	X 1.0510	$219.27
G0070	Adm of chemo drug in home	$259.52	X 1.0001	X 1.0510	$272.78
G0088	Adm iv drug 1st home visit	$187.77	X 1.0001	X 1.0510	$197.37
G0089	Adm subq drug 1st home visit	$253.70	X 1.0001	X 1.0510	$266.67
G0090	Adm iv chemo 1st home visit	$315.62	X 1.0001	X 1.0510	$331.75

Source: The unadjusted CY 2021 PFS rates are calculated based on the updated CY 2021 RVUs which were recalculated after the removal of code G2211 and the unadjusted PFS Conversion Factor which is calculated by removing the 3.75 percent increase in PFS payments for CY 2021

Medicare Provider and Supplier Enrollment Changes

The rule incorporates into regulation several Medicare provider enrollment sub-regulatory policies. These policies involve, but are not limited to: (1) deactivations; (2) the rejection and return of provider enrollment applications; and (3) the establishment of effective dates for various provider enrollment transactions.

Survey and Enforcement Requirements for Hospice Programs

CMS is finalizing provisions to implement Division CC, section 407(a) of the CAA 2021 with respect to transparency, oversight, and enforcement of health and safety requirements for hospice programs.

These provisions "enhance the hospice program survey process by requiring the use of multidisciplinary survey teams, prohibiting surveyor conflicts of interest, expanding CMS-based surveyor training to accrediting organizations (AOs), and requiring AOs with CMS-approved hospice programs to begin use of the Form CMS-2567. Additionally, the provisions require that state survey agencies establish a hospice program complaint hotline. Finally, the rule implements the CAA 2021 provision requiring the

establishment of enforcement remedies that may be imposed instead of, or in addition to, termination of participation in the Medicare program for noncompliant hospice programs. We are finalizing the proposed surveyor prohibition of conflicts of interest and enforcement remedy provisions as proposed with two exceptions. First, we are not finalizing our proposal for the Special Focus Program for poor-performing hospice programs that have repeated cycles of serious health and safety deficiencies. Numerous comments indicated CMS should not finalize the proposed provision until a Technical Expert Panel (TEP) is convened to further define the parameters and provide a targeted approach based on national measures. Therefore, we are establishing a TEP with stakeholder engagement that integrates the public comments and will finalize this program through future rulemaking. Second, the suspension of payment enforcement remedy will be finalized with modifications to limit the suspension of payment to all new patient admissions, rather than suspension of all or part of the payments to which a hospice program would otherwise be entitled."

The CAA 2021 provisions expanding requirements for AOs will apply to AOs that CMS has approved to accredit hospice programs. CMS "deems" accredited hospice programs to meet Medicare requirements. Currently, there are three CMS-approved AOs for hospice programs: Accreditation Commission for Health Care (ACHC), Community Health Accreditation Partner (CHAP), and The Joint Commission (TJC). Half of all the Medicare-certified hospices have been deemed by these AOs.

Comment

The above material extends more than 60 pages.

Requests for Information -- Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Quality Reporting Programs (QRP)

"CMS is working to further the mission to improve the quality of health care for beneficiaries through measurement, transparency, and public reporting of data. We believe that advancing our work with use of the FHIR standard offers the potential for supporting quality improvement and reporting, which will improve care for our beneficiaries. We received feedback on our future plans to define digital quality measures (dQMs) for the Home Health QRP. We also received feedback on the potential use of FHIR for (dQMs) within the Home Health QRP aligning where possible with other quality programs. We are currently analyzing the feedback received for future consideration in program development and future rulemaking."

Revised Compliance Date for Certain Reporting Requirements Adopted for Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) and Long-Term Care Hospital (LTCH) QRP

Revised Compliance Date for Certain Inpatient Rehabilitation Facility (IRF) QRP Reporting Requirements

CMS is finalizing its proposal that "IRFs begin collecting the TOH Information to Provider-PAC measure, the TOH Information to the Patient-PAC measure, and on the six categories of Standardized Patient Assessment Data Elements on the IRF-PAI V4.0, beginning with admissions and discharges (except for the hearing, vision, race, and ethnicity Standardized Patient Assessment Data Elements, which would be collected at admission only) on October 1, 2022."

Revised Compliance Date for Certain Long-Term Care Hospital (LTCH) QRP Reporting Requirements

CMS is finalizing its proposal that "LTCHs begin collecting the TOH Information to Provider-PAC measure, the TOH Information to the Patient-PAC measure, and on the six categories of Standardized Patient Assessment Data Elements on the LCDS V5.0, beginning with admissions and discharges

(except for the hearing, vision, race, and ethnicity Standardized Patient Assessment Data Elements, which would be collected at admission only) on October 1, 2022."

COVID-19 Reporting Requirements for Long Term Care Facilities

CMS is finalizing the requirements at §483.80(g)(1) through (3) with the following modifications: (1) Reporting frequency of the information specified in §483.80(g)(1) is modified to weekly, unless the Secretary specifies a lesser frequency; (2) Reporting data elements are unchanged, but may be reduced, contingent on the state of the pandemic and at the discretion of the Secretary; and (3) with a sunset date of December 31, 2024 for all reporting requirements, with the exclusion of the requirements at § 483.80(g)(1)(viii).

Final Thoughts

While the table of contents is helpful, it could be much better for the reader if all heads and subheads would be identified.

The fact that the rule contains "Final Decision" paragraphs is very helpful. However, many subjects are addressed in multiple locations. This causes confusion in understanding many provisions.

As is apparent, this analysis cannot reflect all changes in the 500+ page rule. An in-depth review is required to fully comprehend the changes being presented.