

August 27, 2021

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1747-P,
P.O. Box 8013,
Baltimore, MD 21244-1850

Re: 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

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule in regard to its effects on those living with serious illness.

C-TAC is a national non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is made up of over 170 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

Here are our comments:

Home Health Value-Based Payment (HHVPB) Model Expansion Quality Measures

We support the aim of this model to use VBP to improve the care of those receiving home health. VBP is the best way to pay for care for those with serious illness as it allows for a broader range of services, and a fuller interdisciplinary team to deliver them, than traditional fee-for-service payment.

However, we note that while advance care planning was one of the self-reported measures previously in the demonstration, it is not being proposed for the expanded model. This is a mistake since all care should be grounded in the goals and preferences of the beneficiary and one way to do this is via advance care planning. In fact, CMS Administrator Ms. Brooks-LaSure recently emphasized that person-centered care is a priority for the agencyⁱ and to

best ensure such care, processes like advance care planning should be prioritized. Unfortunately, evidence shows these planning conversations do not yet occur widely with Medicare beneficiariesⁱⁱ and, to correct that, we are advocating that it be required in all Medicare programs and models.

Looking at the composite measures for the HHVBP, we also see that they focus on improvement in mobility and self-care. While it may have been the initial intent of home health services that patients would show improvement in those areas, that is not the case for those with chronic, progressive illnesses. (The proposed rule also only mentions risk adjusting these measures to account for cognitive status, not disease status.) Maintenance of function or even slowing its decline is the more appropriate goal for those with progressive illnesses. And, by penalizing home health providers for not showing improvement on these areas, the HHVBP may inadvertently dissuade them from providing care to those with such illnesses. Therefore, we recommend adjusting these measures accordingly or developing additional ones that allow for maintenance or slowing the decline of function.

Home Health QRP

We support the proposed measure changes but also, in line with the HHVBP comments, recommend that advance care planning be added to the QRP along with measures about referral to hospice and referral to palliative care services. While some of the beneficiaries receiving home health services will recover from their illness, many will continue to live with serious or chronic conditions and, for them, timely referral to hospice or palliative care would be appropriate to improve both their quality of life and that of their family caregivers.

Home Health Conditions of Participation

- Telehealth and Home Health Aides- We support the continued use of telehealth to supervise home health aides as this is a practical solution to the challenges the pandemic has caused to health care provider and workforce staffing.
- Adequacy of aide staffing- We thank CMS for raising this important topic and seeking stakeholder input. Our suggestion is to explore expanding which organizations can train and certify their own home health aides. A related issue is to allow flexibility so that aides trained and certified in one state be allowed to work in neighboring states since the current state-based requirements are a limitation to both these workers and the organizations that hire them.

Survey and enforcement requirements for hospice programs

- Survey requirements-We support the provision in the Consolidated Appropriations Act (CAA) 2021 that makes permanent the requirement that routine hospice surveys be conducted, at a minimum, every 36 months. As part of this proposed rule CMS has indicated that some type of standard framework that identifies key survey findings may be needed. We believe that the most effective means for achieving this level of

transparency is through engagement in a deliberative process which identifies for display key elements related to Medicare survey performance that will be most useful to the public, along with establishment of a means for conveying survey performance on hospice Conditions of Participation (CoPs) that are most closely linked to quality of patient care (specifically the four core CoPs), and from which a summary report or metric could be created and posted online.

We also recommend that any posting related to survey findings in which a provider was cited for failure to meet the hospice CoPs includes a notation that the provider has corrected any deficiencies and is in full compliance with the hospice CoPs, and the date that the hospice achieved full compliance. If a hospice is deemed by an accrediting organization, the notation should include notice that once compliance was achieved the hospice was once again accredited by the AO.

- Surveyor Qualifications - We recommend that the surveyors also be required to do state training and that CMS, and the states, report statistics on how many are trained, how many certified, etc. We also recommend that this process be centralized out of CMS' federal office rather than regionally as there is too much variation across the regions. (Complaints, of course, would still be handled regionally.) CMS should also establish an ongoing requirement for continuing surveyor eligibility that includes continuing education requirements and ensures that a surveyor conducts a minimum number of surveys on a provider type annually to maintain credentials.
- Surveyor Prohibition of Conflicts of Interest- We recommend that CMS strengthen the exclusions to include current or former competitors or family members from being able to be surveyors. In smaller communities, this may be challenging, but is important to maintain the objectivity of the surveys.
- Special Focus Programs- We support the additional and targeted oversight and termination of Medicare certification, as appropriate, for hospices not delivering quality care. We have concerns, however, with suspending payment as being too strong a remedy since this could severely undermine the viability of a hospice organization and so should only be used as a last resort and when all other enforcement measures are exhausted. An interim step could be partial suspension and an order of correction. We also recommend CMS incorporate a dispute resolution process into the reforms since hospices will be subject to more severe consequences for noncompliance.

Closing the equity gap request for information (RFI)

Here are our responses to some of the requested guidance on any additional Standardized Patient Assessment Data Elements that could be used to assess health equity in the care of HHA patients for use in the HH QRP:

- In addition to the SPADES requirement from the IMPACT Act of 2014, we would recommend expanding provider education and incentives for improved SDOH assessment and data collection including for self-identified race and ethnicity, preferred

language, interpreter services, health literacy, transportation, and social isolation. These all relate to social risk factors that can affect the lives of those living with serious illness.

- We also recommend CMS explore better data collection on factors such as availability of caregiving, housing scarcity, food scarcity, marital status, socioeconomic status, education level, housing stability, food insecurity, violence, and safety concerns since these are additional social risk factors that should be identified and, ideally, addressed through collaboration with community-based services.
- Where possible, we recommend that data on family caregivers and their level of burden be also measured. This is a factor in minority communities and HHAs are in a convenient position to gather it given they are in the home setting.
- Finally, we recommend that data be self-reported where possible, as the nuances of a person's background cannot always be gleaned from checking standardized options.

Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Quality Reporting Programs – RFI

We strongly support the PACIO project on making advance directive information interoperable among post-acute settings and have been participating in that effort. We appreciate that CMS recognizes the need for interoperability in this area and look forward to implementation of the guide that this project will deliver this fall. Please let us know if we can be of any further help.

We also recommend investing in and supporting the use of IT among community-based organizations that address patients' social needs. Such organizations need to be able to better coordinate with health care organizations and information. At present, many lack the financial resources or expertise to invest in such IT systems on their own but, as they are an important part of the post-acute world and providing additional care to those with serious illness, they need to have interoperable IT to fully participate.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact me, Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

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ⁱ <https://www.healthaffairs.org/doi/10.1377/he20210803.199350/full/>

ⁱⁱ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01895>