C+TAC
COALITION TO TRANSFORM
ADVANCED CARE

August 20, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Re: Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule regarding its effect 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 comprises more than 200 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.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF).

Serious illness is also a health equity issue. A history of disenfranchisement has led to healthcare gaps across the country. Per a 2021 Commonwealth report on racial and ethnic health equity, communities of color live fewer years, on average, than white people do, are more likely to die from treatable conditions, and are also at higher risk for many chronic health conditions. For serious illness, the lack of access to health insurance and primary care means many are diagnosed only at a late or end stage of illness, when disease-modifying treatment is typically no longer effective. Those from historically under-resourced communities who also have serious illness experience poorer care and access, making improving their care a health equity opportunity.

Here are our comments on the pertinent parts of the proposed rule:

Home Health Quality Reporting Program (HH QRP
We support the addition of the new items as standardized patient assessment data elements under the social determinants of health (SDOH) category. These are all important areas that affect health and quality of life. Our suggestions on this are:

- Financial insecurity- It may perhaps make more sense to assess for overall financial challenges since that underlies all of the above SDOH areas. People have housing, food, utility, and transportation issues if they lack adequate financial resources.

- Services delivery- Once assessed, any needs also need to be addressed with referrals to appropriate services and a mechanism in place to confirm that these referrals resulted in actual service delivery. Referring people to service waiting lists is not the goal but instead to the actual services themselves.

HH QRP Quality Measure Concepts under Consideration for Future Years – Request for Information (RFI)
We appreciate the opportunity to respond to the following in this RFI:

- Pain Management- We support this measure concept and would encourage any measures to follow the CDC Clinical Practice Guideline for Prescribing Opioids for Pain as some HH patients may appropriately need these medications, yet there are key populations that should be excluded from any measures that could reduce their access to these medications. We also suggest considering the new Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain to the HH QRP as a way to include the patient's voice on this important area.

- Depression- We support this measure concept as depression can strongly affect health and quality of life and is often a factor for those living with serious illness.

RFI on Future Performance Measure Concepts for the Expanded HHVBP Model

- Family caregiver measure- We support the development of such a measure, which is in line with the TEP's recommendation. We also look forward to learning about such a measure in the GUIDE Dementia model. However, in the meantime, CMS should consider assessing for family caregiver burden in the HHVBP model as this can be a factor in both the patient's health and the use of emergency department visits or hospitalization.

One additional thing to note is that there is not an EMR standard for noting who the patient's key caregiver is. This role may differ from the required key contact or medical decision-maker and is important information to capture. Perhaps CMS could work with ONC to add this to future EMR requirements.

- Function measures to complement existing cross-setting Discharge (DC) Function measure- We have consistently supported measuring function in all the Medicare programs as it is an important health and quality of life factor. We agree that this measure should include the full self-care/activities of daily living elements along with functional cognition as these are important factors to note and address whenever someone is discharged from this model.

We also suggest the following potential performance measures for this model:

- Patient Experience of Care/Patient Satisfaction- We support measure development in this area as patient self-report is the gold standard to assess care quality. We therefore recommend again the Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain again and also the 2024 MIPS Measure #495: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood. Both are appropriate for the HHVBP model to get direct patient self-report on these important aspects of care.

- Advance care planning (ACP): ACP is a nuanced process through which patients identify their goals and consider their preferences for medical care over time. While the evidence base for ACP is mixed, ACP is a HEDIS measure, a MIPS clinical quality measure, and there are CPT billing codes to cover the service. It should therefore be part of the HHVBP model and all Medicare programs as a way to ensure that the care being delivered is the care that the person wants. Recent evidence also shows disparities in advance care planning among minority groups, so promoting it could help reduce inequity.

- Palliative care access and utilization- People with serious illness benefit from the inclusion of palliative care services in their care. By palliative care, we mean the CMS definition of "*Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice".* Therefore, we suggest considering a measure in the HHVBP model on referral or access to palliative care to measure how many of those with serious illness getting home health care are also utilizing these important services. We would also note that CMCS's recent approval of adding palliative care services to the Hawaii Medicaid program has redefined palliative care as a preventive service. This makes it even more appropriate for those in the HHVBP model.

- Timely and appropriate referral to hospice- Although the goal of home health care is to restore function, some patients will likely be in the last stage of illness and therefore, the transition to hospice should be promoted when appropriate. We suggest a measure to ensure that a hospice referral is considered in such cases and that the patient's eligibility for hospice is assessed and hospice offered. A claims-based outcome measure could capture the percent of model beneficiaries that transition to hospice and of those hospice patients, whether referral to hospice was timely based on hospice length of stay, i.e., less than seven days, etc.

- Interoperability- The proposed rule does not address this issue for home health, so we raise it as it is a factor in discharging patients from the hospital to home health and other post-acute types of care. While not a measurement opportunity, we include it as something else for CMS and ONC to collaborate on.

RFI the Initial and Comprehensive Assessment

C-TAC consistently advocates for comprehensive assessment as an important way to identify a person's issues and needs across a range of domains. We, therefore, very much appreciate its definition in section 484.55(c), which establishes the minimum content of the comprehensive assessment to be that "*which must accurately reflect the patient's status and include the patient's current health, psychosocial, functional, and cognitive status. The comprehensive assessment must also reflect the patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward the achievement of the goals identified by the patient and the measurable outcomes identified by the HHA. Additionally, the comprehensive assessment must include a determination of the patient's continuing need for home care and regarding rehabilitative therapists conducting their medical, nursing, rehabilitative, social, and discharge planning needs. Further, the comprehensive assessment must also include a review of the patient's medication and identify the patient's primary caregiver(s) or patient representative*".

We also support the proposed continuation of allowing rehabilitation professionals to perform the initial and comprehensive assessment in instances when both nursing and therapy services are ordered. This makes sense as these professionals are already seeing home health patients and doing an assessment. They may also be the key team members working with these patients and so should be allowed to do the comprehensive assessment as well. We would just suggest that they have the training to do so for assessment areas, like social risk factors, that might fall outside of their typical area of expertise.

Plan of Care Development and Scope of Services Home Health Patients Receive

We appreciate CMS' focus on this important issue. C-TAC's coalition membership is broad, yet all agree that focusing on the patient and their goals and preferences is our guiding principle. We, therefore, feel that it is unfortunate that some beneficiaries report difficulty finding an HHA to accept them for service or complain that sometimes HHA services are being altered or diminished from the original plan of care without an accompanying reduction in patient needs or achievement of the measurable outcomes and goals set forth in the plan of care. While we do not have specific data or anecdotes to report in response to the questions listed in the proposed rule, we applaud the agency's effort to learn more about this issue to address it in future rulemaking. Our suggestion for such rulemaking is to balance protecting patients and access with not imposing too much administrative burden on those HHAs operating in good faith.

Proposed Provisions - Provisional Period of Enhanced Oversight (PPEO)
Related to the above, we agree that the proposed PPEO is appropriate and are familiar with this from our hospice members. However, they and we would urge you to target any oversight towards the most egregious bad actors rather than burdening those HHAs operating, again, in good faith.

ICRs Related to Conditions of Participation (CoPs): Organization and Administration of Services
In our mission to protect patients and their family caregivers, we support this proposal. We also support requiring the HHA to make public accurate information about the services it offers, and any limitations related to the types of specialty services, service duration, and service frequency.

Our only question is whether an annual update will indeed be accurate or if HHAs should be required to update this information in real-time whenever services change. That seems the only way to ensure that the public will have access to "accurate" HHA information.

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

Sincerely,

Marian Grant

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