August 15, 2022

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

Submitted electronically to http://www.regulations.gov

Re: CMS-1766-P. Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to comment on this Medicare home health proposed payment rule. Our comments will focus on monitoring the effects of the implementation of the Patient Driven Groupings Model (PDGM), the statutory behavioral payment adjustments required after the change to a 30-day episode of care, the collection of claims data on the use of telecommunications technology in home health, the Home Health Quality Reporting Program, equity, and the Expanded Home Health Value-Based Purchasing (HHVBP) Model.

MONITORING THE EFFECTS OF THE IMPLEMENTATION OF THE PDGM

The PDGM, implemented in 2020, made significant changes to the home health prospective payment system (HH PPS), including replacing 60-day episodes of care with 30-day periods of care, removing therapy volume for directly determining payment and developing 432 case-mix adjusted payment groups in place of 153 groups. As part of its effort to monitor the implementation, CMS provided updated data in the CY 2023 proposed rule on home health utilization patterns before and after PDGM implementation.

As AARP has noted in prior comments, we continue to note trends observed in the CMS-provided data that highlight potential concerns and negative impacts on beneficiaries. The total number of visits per 30-day period of care has decreased by nearly 17 percent from 9.86 in 2018 to 8.22 in 2021. This continuous downward trend is concerning as implementation of the PDGM could be having potential unintended consequences, such as potential stinting of care through inappropriately early discharge from home health or inappropriately limiting the number of visits.
or types of services provided. In addition, CMS data show that the number of home health visits per 30-day period of care by home health aides continues to trend downward, decreasing by 35 percent from 0.72 visits in 2018 to 0.47 visits in 2021, with nearly a 13 percent decrease from 2020 to 2021 alone. At the same time, CMS reports that the proportion of 30-day periods of care with no home health aide and/or social worker continues to increase, rising from 83% in 2018 to 88% in 2021. CMS also cites declines in skilled nursing, physical therapy, occupational therapy, and speech therapy in 2021 versus 2018.

AARP is concerned about these persistent downward trends and lack of data or analysis by CMS to indicate whether the appropriate level of home health care is being provided to beneficiaries to meet their needs. The increased use of telehealth services during the public health emergency (which is not captured in these data) may explain some of the decline of in-person visits, but AARP believes the use of telehealth should complement in-person care and not be a substitute for in-person home health care needed by beneficiaries. This shift in payment incentives may be encouraging agencies to focus on serving post-hospital clients for short periods of time and discouraging them from serving people with longer-term needs. We also believe that CMS should expand the data it collects to include uniform data collection including geographic, racial, ethnic, socioeconomic, sexual orientation and gender identity identifiers, to identify whether disparities in telehealth usage vary in diverse populations receiving or seeking to maintain or obtain services. Recent research has shown that African American/Black and Hispanic/Latino patients received home health at lower rates than did patients who were White, and socioeconomically disadvantaged patients waited longer for their first home health care visit.1 Moreover, as discussed below, CMS should begin to collect claims-level data on telehealth in home health care to monitor its use.

While monitoring utilization is necessary, it is not sufficient, and we encourage CMS to supplement its analysis of utilization data with additional monitoring tools. AARP also urges CMS to closely monitor the impacts of any changes in payment policy on the quality of and access to Medicare home health services in as close to real time as possible. One helpful tool may be surveys of Medicare beneficiaries using home health services and their family caregivers, as appropriate. Study of beneficiary appeals should also be considered as part of this assessment. We also urge CMS to exercise appropriate oversight and enforcement to ensure that beneficiaries receive services under the Medicare home health benefit that they are eligible for and need, including home health aide visits, which are an important part of the Medicare home health benefit.

In addition to the CMS-reported data on home health agency (HHA) utilization and cost measures, we suggest that additional data be collected that would more completely reflect the impact on Medicare beneficiaries of the PDGM implementation. Such measures should be person-centered, to include patient reported outcomes and patient experience. Such measures should also include, if possible, clinical outcomes before and after implementation, such as changes in function, mobility, complications (e.g., bed sores, dehydration, fever, infections, such as urinary tract infections or pneumonia), and avoidable hospital use (i.e., emergency room,

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observation, or inpatient admission). These measures, as well as utilization and cost measures, should be reported for patient subgroups, to the extent possible, such as subgroups defined by admission source and period timing, and subgroups by key demographic characteristics such as age, race, ethnicity, and functional status. We urge CMS to take any needed action to ensure that all beneficiaries have access to the home health care they are eligible for and need, including home health aide visits.

AARP notes that Medicare beneficiaries who may need and be eligible for the Medicare home health benefit may not access the benefit because physicians and other health care professionals are often not fully aware of it, and thus do not always order or prescribe these services regardless of beneficiaries’ actual needs or eligibility to receive the services. We urge CMS to educate physicians, social workers, discharge planners, care coordinators, and other health care professionals about the Medicare home health benefit, so they are informed and can appropriately order or suggest it for Medicare beneficiaries who need these important services. In addition, we note that provider education to include required provider led beneficiary outreach and education for family caregivers could also help address inequities, delays, and disparities in access to home health services that some Medicare beneficiaries experience.

**METHODOLOGY FOR BEHAVIORAL ASSUMPTIONS AND ADJUSTMENTS**

AARP understands that CMS is required by statute to make both permanent and temporary adjustments to the home health payment rate to ensure aggregate spending neither increased or decreased as a result of the new unit of payment and elimination of therapy thresholds from the implementation of the PDGM. CMS estimates that it would need to apply a -7.69 percent permanent adjustment to the 2023 base payment rate as well as implement a temporary adjustment of approximately $2.0 billion to reconcile retrospective overpayments in 2020 and 2021.

AARP recognizes the need for CMS to apply the permanent adjustment this year and that delay in applying this adjustment would likely lead to a compounding effect and require an even larger reduction to the payment rate in future years. We are concerned, however, that also applying the temporary adjustment in 2023 to HHA payments would adversely affect access for Medicare beneficiaries given the potential large reduction in payment in one year. Thus, AARP agrees with CMS that it should delay applying the temporary adjustments until a future payment year. We also recommend that when implemented, these temporary adjustments should be phased-in over a period of time to help ensure that these payment reductions are less likely to adversely impact Medicare beneficiary access to home health care, especially beneficiaries in traditionally marginalized communities including beneficiaries of color.

**COMMENT SOLICITATION ON DATA COLLECTION ON THE USE OF TELECOMMUNICATIONS TECHNOLOGY**

AARP is supportive of CMS’ proposal to collect data on the use of telecommunications technology on home health claims. The use of telehealth visits in home health appears to have

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2 Sections 1895(b)(3)(A)(iv) and 1895(b)(3)(D) of the Social Security Act
greatly expanded as HHAs expanded their programs in response to the PHE. As noted above, we believe that monitoring the effects of the implementation of the PDGM requires complete and comprehensive data. This data is not currently collected on home health claims and CMS does not review plans of care to determine whether these services are being provided. Collecting claims-level data would be beneficial as it would give CMS a broader understanding of how home health services are furnished – whether in-person or by telehealth visits – and use that information to further evaluate who benefits from these services, and whether there are differences in quality between in-person vs telehealth visits and, particularly, whether there are differential access for certain subsets of beneficiaries or certain communities. Thus, we are generally supportive of the CMS proposal to create specific G-codes to capture this information that will allow differentiation of services as well as the clinician performing the services. Importantly, we strongly encourage CMS to use the data to evaluate and immediately address any observed disparities.

As noted in past comments, AARP believes that telecommunications systems can be useful to Medicare beneficiaries and family caregivers when they augment the care already provided by HHAs. We agree that when HHAs furnish services via a telecommunications system, they should not substitute for in-person home health services ordered by a physician or other health care professional under the plan of care and they should not be considered a home health visit for purpose of eligibility or payment. We also agree with CMS that the use of telecommunications technology is generally not appropriate for home health aide services. There may be exceptions when a home health aide might use telecommunications technology, such as to respond to a question or urgent need of a care recipient or their family caregiver, but this should be rare, as these aides are generally providing hands-on care. While certain tasks cannot/should not be done remotely, technology can allow for other tasks that would not otherwise have been performed such as mental health and isolation checks or medication management. For example, remote patient monitoring should not substitute for appropriate face-to-face visits and is not appropriate for all patients in all situations. However, for home-based Medicare beneficiaries with chronic conditions, limited mobility, and lack of ability to accurately collect and communicate health-related data, remote patient monitoring can be helpful. It is also important that beneficiaries who can participate in remote monitoring do so only as a matter of consumer choice.

HOME HEALTH QUALITY REPORTING PROGRAM (HH QRP)

All-Payer Outcome and Assessment Information Set (OASIS) Data Reporting

CMS proposes to require HHAs to submit all-payer OASIS data for purposes of the HH QRP beginning with the CY 2025 program year and to employ a phased transition such that full implementation occurs beginning with CY 2026. AARP supports resumption of all-payer OASIS reporting and we agree with CMS that doing so is responsive to stakeholder calls for increased data standardization across post-acute care (PAC) settings; adds to alignment of policies and reporting requirements across PAC settings; facilitates identification of outcomes disparities across PAC settings and patient subsets; and provides a fuller, more accurate representation of

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home health quality of care for use in beneficiary health care decision making, policy development, and health services research.

AARP also appreciates the significant degree of transparency about the HH QRP that is added by resuming all-payer OASIS reporting. When information is publicly reported and presented in a way that allows comparison, it directly benefits individuals and their family caregivers at times of transitions so they can be well-informed consumers. Public reporting is also critical for promoting provider accountability and ensuring that frail adults are protected and receiving appropriate and high-quality care. We are conscious of the consumer privacy concerns that previously led to cessation of all-payer reporting, but we are confident that proper safeguards will enable CMS to protect consumers while enabling CMS to see the full picture of disparities across payer categories.

**Codification Of Measure Removal Factors**

CMS proposes to codify previously finalized factors for consideration to be applied when considering removal of a measure from the HH QRP measure set. AARP supports the proposal for codifying these factors in regulation text where they will be accessible by the public. Transparency about these factors and the measure selection, addition, retention, revision, and removal processes is key to ensuring that the measures remain beneficiary-focused.

AARP appreciates that CMS routinely addresses all proposed changes to the HH QRP measure set annually through Home Health Prospective Payment System (PPS) notice-and-comment rulemaking. We strongly support this approach for keeping beneficiaries and all other interested parties informed and we urge its continued use rather than publicizing changes only through sub-regulatory guidance mechanisms. We also recommend that CMS be cautious when determining that changes are “technical” in nature as a rationale for choosing the sub-regulatory approach. We appreciate that CMS has increasingly used notice-and-comment rulemaking as a vehicle for announcing technical changes, allowing such changes to reach a broader audience than is reached through sub-regulatory guidance, particularly regarding beneficiary and other consumer perspectives.

That said, AARP continues to oppose the use of the most recently finalized measure removal factor -- “the costs associated with a measure outweigh the benefit of its continued use in the program.” As we have previously commented, while we understand the goal of ensuring that quality measures yield meaningful benefits, we do not support using this criterion as a basis for removing an existing measure. We believe that the other seven removal factors suffice to achieve this goal. It is difficult or impossible to measure the benefits to Medicare beneficiaries (such as good quality of care, timely care, good communication between providers and individuals and their family caregivers, and quality of life) using a dollar metric. Further, benefits accrue to beneficiaries, while costs are typically borne by providers – these are not equivalent or interchangeable. The eighth factor allows providers to try to drop measures they do not want to collect or report for various reasons (such as saving costs on measures on which they perform poorly), but which are important to beneficiary outcomes.
Request for Information (RFI) on Health Equity in the HH QRP

Structural Measure of HHA Commitment to Equity

In follow-up to an equity focused RFI issued during CY 2022 Home Health PPS proposed rulemaking, CMS now asks for feedback about a potential structural measure of equity applicable to HHAs. The measure’s description is similar to one proposed for addition to the hospital inpatient quality reporting program by CMS in FY 2023 and later finalized.

AARP firmly believes that ensuring health care equity promotes better quality for all older Americans and we commend CMS for its sustained commitment to exploring issues of health equity and care disparities in the HH QRP and other Medicare quality programs. We strongly agree that it is imperative for efforts to advance health equity to be operationalized across all care settings. We note that attention must also be paid to disparities that may arise during transitions between care settings, when gaps in the care continuum are known to occur and may disproportionately affect disadvantaged populations. For instance, are there differences by race and ethnicity in assignment to home health care versus skilled nursing facility care at hospital discharge? CMS would appear to have the data required to compare ratios of patients discharged to various PAC settings and to examine results stratified for demographic and social risk variables of interest. Such comparisons could shed light on disparities in access to care.

CMS expresses interest in structural measures that assess an organization’s leadership in advancing health equity goals or assess progress towards achieving equity priorities. In the short-term, carefully constructed structural measures could provide insights to agencies about the extent to which health equity has been incorporated into their organizational cultures. In general, however, we view structural measures as merely initial steps that must soon be replaced by process measures with links to outcomes as well as actual outcome measures, including consumer experience-of-care measures and other patient-reported outcomes. Therefore, we conceptually support a structural measure of HHA commitment to equity as a first step, but importantly we offer suggestions for strengthening CMS’ proposed measure. As outlined, the elements and domains lack specificity of what could qualify under these elements, without which it is unclear how their completion could advance health equity.

CMS suggests a measure format having three domains and multiple elements within each domain. To satisfy a domain, an HHA would need to show evidence of activities for all domain elements through some combination of attestation and documentation submitted via a CMS portal. Completion of the domain would be worth one point. We think the measure format, domains, and elements proposed for this measure are the absolute minimums that should be required initially, but we strongly urge CMS to strengthen the proposed measure before implementation. We urge CMS not to delay providing greater element specificity, increased emphasis on providing documentation of efforts rather than merely attestation to their completion (e.g., provision of CMS templates or checklists for reporting elements and activities), and auditing documentation of element completion rather than relying solely on attestation. Other domains to consider adding to the measure immediately or very soon include those addressing community engagement and workforce. CMS may also want to consider keeping the different domains of the measure as separate scores in terms of information for consumers and
their families and not just a composite score. Doing so would potentially provide more actionable information for consumers.

Below we also offer suggestions for additional elements and other feedback organized by our understanding of the domains and elements outlined by CMS for the measure.

**Domain 1: Equity is a key organizational priority and is reflected in a strategic plan for advancing equity**
- Require that the plan include approaches to address health equity (including implicit bias, which could be included on the attestation checklist) and clearly state how progress and success in achieving equity will be determined and measured
- Require that the plan incorporates feedback from stakeholders, including beneficiaries and their family caregivers (not just engagement, activities, and seeking input)
- Require that the HHA has publicly posted its strategic plan (which helps with stakeholder feedback) and that beneficiaries and their family caregivers are informed about the plan soon after the home health episode of care begins
- Provision by CMS to HHAs of supporting materials (e.g., validated survey questions for patients and families, such as from Home Health Consumer Assessment of Healthcare Providers and Systems Survey, HHCAHPS) and/or technical assistance such as from quality improvement organizations (QIOs), particularly to agencies serving large numbers of beneficiaries who may experience inequities or disparities in care, and/or located in a resource-poor community or one that has been underinvested in, or smaller agencies to assist with implementation of domains and elements in this measure.

**Domain 2: Appropriate diversity, equity, and inclusion training is provided**
- Organization-wide training and training staff to provide culturally and linguistically appropriate care is essential, but is not a replacement for having a diverse workforce that reflects the community the HHA serves at all levels of the organization (including leadership and board members) and who can communicate fluently, having resources so that translators are available, etc.
- Include requirements for reporting on HHA staff training, and specific trainings and requirements. The training should consider diverse abilities and language preference.
- Where possible, CMS through technical assistance, QIOs, or similar approaches, should offer standardized training and other tools to assist HHAs, especially those noted above in Domain 1
- Establish metrics to assess progress, quality, and success of the required training, incorporating actual patient experiences and outcomes
- Include education about overarching principles and concepts such as person- and family-centered approaches and consumer-directed practices in service planning and delivery
- Routinely obtain feedback from trainees at all levels about how to improve the training plan, materials, format, and teacher effectiveness
- Require beneficiary and family caregiver input into training and resource materials
- Require that feedback about the effectiveness of training be obtained from patients and family caregivers
- Consider engaging trainees, patients, and caregivers voluntarily in real-time training scenarios
Domain 3: Demonstrating an organizational culture of equity

- Define criteria by which progress and success will be assessed
- Incorporate elements that reflect the characteristics of the community served by the HHA
- Consider selected use of 360° evaluations by staff of leadership
- Conduct exit interviews with patients and family caregivers that address questions of discrimination
- Consider an HHA access equity measure. Disparities in HHA screening or patient acceptance decisions could embed inequity into an agency’s environment and culture, a downstream consequence of which would be an implicit perpetuation of disparities. CMS should consider the best way to design this, but one idea for consideration is that relevant measures could take the form of a simple ratio (HHA admissions or decisions to accept patients divided by HHA applications (or similar)/referrals with stratified reporting by race, ethnicity, or other demographic and social risk factors, such as written or spoken language).

Other Considerations Related to Equity in the HH QRP

CMS also requests general input about developing future health equity-related measures, particularly those based on information collected by some or all HHAs but not available on claims, OASIS assessments, or other publicly available data sources. First, AARP recognizes and applauds CMS for the Social Determinants of Health category that already is part of required reporting of Standardized Patient Assessment Data Elements (SPADEs) through OASIS and other PAC assessment instruments that will begin in CY 2023.

AARP cannot state strongly enough the importance of developing one or more measures that capture information about family caregiver status, involvement in a beneficiary’s care, and support provided to the caregiver(s). Specifically, we recommend adopting measure(s) that address HHAs documenting whether the beneficiary has a family caregiver and identifying that individual to the HHA including contact information (with the consent of the beneficiary and the family caregiver), whether the care or discharge plan relies on the family caregiver who voluntarily agrees and is able to provide assistance, and, if so, whether the family caregiver was provided supports they need as part of the plan after determining a need for such supports (such as education and training). We also recommend a measure of family caregiver experience of care and urge that Caregiver Status be added to the list of SPADEs required for reporting. Family caregivers can be critical to enabling the individuals they assist to remain at home, as well as avoid unnecessary emergency room visits, and hospital and nursing home stays. Caregivers also provide continuity of care and care coordination.

Caregiver information is important, relevant, and applicable to assessment of all patients receiving care in PAC settings but perhaps has the greatest relevance and impact in the home health setting. Regarding equity, absence of an identifiable caregiver also may serve as a marker for other social risk factors that influence patient outcomes (e.g., social isolation) and could be a valuable element for use in stratified performance reports in the search for care disparities. Additionally, family caregivers are an important source of information about patient preferences and whether those preferences are being respected during care delivery by HHA staff members.
Finally, AARP generally supports posting PAC provider performance, including HHAs, on Care Compare. Performance information rapidly loses value unless it is presented in a way that beneficiaries and family caregivers find to be user-friendly, comprehensible, and actionable. AARP strongly encourages CMS to gather feedback directly from these end users (beneficiaries and family caregivers) on how best to present the information to ensure that they are, in fact, able to effectively use the information available.

REQUEST FOR COMMENT ON A FUTURE APPROACH TO HEALTH EQUITY IN THE EXPANDED HHVBP MODEL

Changes To Reflect The Diversity Of The Home Health Patient Population

CMS requests comments about making changes to the Expanded Home Health Value-Based Purchasing model (HHVBP) that would reflect the diversity of the home health patient population as part of the agency’s enterprise-wide commitment to advancing health equity through Medicare’s quality programs. AARP strongly supports the ongoing efforts by CMS to embed health equity and disparities considerations throughout its quality programs. We firmly agree with CMS that the framework of the expanded HHVBP model should support and reward the consistent delivery of high-quality home health services to all patients regardless of their demographic and social risk factors.

Stratified results reporting of robust outcome measures could facilitate the identification of care disparities to be addressed through modifications to the expanded HHVBP model. Reliable stratified results, however, demand consistent collection of standardized data elements, principles for which we have articulated to you in prior comment letters. AARP notes that home health agencies are already collecting and submitting to CMS a variety of standardized patient SPADEs using the OASIS assessment tool and will begin reporting several SPADEs that describe social determinants of health in CY 2023. As in our comments above under the HH QRP and in previous comments, we urge CMS to adopt a measure in the expanded HHVBP that captures information about family caregiver status, involvement in a beneficiary’s care, and support provided to the caregiver(s). Family caregivers play an essential role in beneficiaries’ care and outcomes.

Linking Payments to Outcomes and to Disparities

CMS also asks whether and how home health outcome measures could be tied to the expanded HHVBP model’s payment adjustments and account for care disparities. AARP acknowledges the potential power of payment adjustments as a policy lever but we strongly urge CMS to use this approach deliberatively and with caution with regards to the expanded HHVBP model. AARP remains concerned about the potential for unintended quality and access issues that VBP arrangements might cause or exacerbate for neighborhoods and patients. In developing any financial adjustments, CMS should consider that there may be neighborhoods that are more “difficult” to serve and patients who are more challenging to treat. A VBP context may create or compound disincentives for providers to serve these neighborhoods and/or patients, which may negatively impact health disparities. HHAs played an important role in the COVID-19 pandemic,
as some beneficiaries sought to avoid institutional settings and receive care at home. Some who may have received care in a skilled nursing facility previously may receive care from an HHA now, in addition to those who already preferred to receive care at home.

In the face of continued high demand for high-quality home health care, our overarching concern about the expanded HHVBP model continues to be maintenance of beneficiary access to necessary care and quality care. Excessively stringent model payment design may increase Medicare savings but simultaneously cause home health agencies (HHAs) to leave the market, particularly in rural and other underserved areas. HHAs may also respond to payment pressure by avoiding beneficiaries whose care is perceived as potentially jeopardizing HHA performance scores, yet those beneficiaries may be the ones having the greatest clinical needs for home health services. The risk of unintended and unwanted consequences may be particularly high in a program like the expanded HHVBP model where rewards for excellent performance are funded solely by penalizing poor performers, some of whom may be safety net providers. AARP encourages CMS to be guided by the goals of alleviating disincentives to serve neighborhoods or treat patients who may be more complex due to factors such as social determinants of health (SDOH), fairly compensate providers who serve a higher portion of these neighborhoods or patients, and hold HHAs accountable for health equity outcomes. We note that the risk of perverse consequences may be partially mitigated by the model’s cohort design under which smaller agencies are compared to peers rather than to larger agencies that are more likely to be better capitalized and have more robust infrastructures and thus more readily achieve higher performance scores. However, AARP would like to see better overall reporting on the impact of the HHVBP model. We encourage CMS to report data on process and outcome measures for the HHVBP program related to beneficiary access and outcomes, as well as costs.

Regardless of payment adjustment design, AARP very strongly recommends that CMS have a clear, substantive, ongoing plan to monitor beneficiary home health access in place before full testing of the expanded HHVBP model starts in January 2023. The plan should include tracking the distribution of HHAs in historically underserved areas and their performances. The monitoring plan should be as close to real-time as is operationally feasible and include steps for corrective action if home health providers are found to be avoiding specific neighborhoods, communities, or patients who may be more challenging to treat.

AARP also suggests frequent monitoring of performance data for the HHCAHPS measures for unwanted trends in patient experience-of-care perceptions. Examination of HHCAHPS data using markers such as dual eligible status, SDOH metrics, and zip codes or area deprivation indices might be especially informative. In addition, AARP recommends that performance reports about the model be made publicly available on a regular, frequent basis rather than relying on results dissemination through the usual formal CMMI model evaluation process. While the latter process is required by statute and yields important reports, the timing of the formal reports and the intervals between them are unpredictable and the data reported are often multiple years old.

Finally, with respect to using stratification (such as based on dual status or other metrics), or adopting new measures of SDOH, AARP believes stratification is a necessary step to both highlight disparities and develop action steps to address it. Dual status, at present, is available
and should be used where SDOH data are not available. However, as AARP has noted in other comments to CMS, dual status does not reflect many other social risk factors that have equal or even greater effect on patient outcomes, and it does not reflect bias and discrimination that some populations may encounter which affect access, care, and outcomes.

Having SDOH metrics is also important for adding specific information about the population served. Standardized SDOH data are currently available and we urge CMS to identify and incorporate domains for stratification that more accurately capture the social and economic environment that consumers and their families face, to achieve more equitable care. Further, AARP encourages CMS to be cognizant of measure harmonization concerns, as well as to use standard definitions and metrics to make comparisons more meaningful.

**NURSE PRACTITIONER, CLINICAL NURSE SPECIALIST, AND PHYSICIAN ASSISTANT ORDERING OF MEDICARE HOME HEALTH**

AARP supported Section 3708 of the CARES Act (P.L. 116-136), which authorizes nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) as eligible health care professionals who can order and certify patients for eligibility for home health services under Medicare and in the same manner and to the same extent under Medicaid. This change can improve access to home health services and potentially reduce costly admissions to hospital, sub-acute care, or nursing facilities. As CMS continues implementation of this provision, AARP calls on CMS to assure that its Carrier Manuals and all sub-regulatory guidance documents are consistent with the law and regulations and make clear that additional documentation of collaboration is not required in states that do not explicitly require collaboration or documentation of collaboration with other providers.

**CLOSING**

AARP appreciates the opportunity to comment on this proposed rule. We urge CMS to keep the needs of Medicare beneficiaries and their families front and center as you finalize this rule and make longer-term policy decisions. If you have any questions, please contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at 202-434-3791.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs