



August 28, 2023

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–1780–P. Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements

Dear Administrator Brooks-LaSure:

AARP, which advocates for the more than 100 million Americans age 50 and over, appreciates the opportunity to comment on this Medicare home health payment proposed rule, which is important to Medicare beneficiaries receiving home health care and hospice services and their family caregivers who often assist with their loved ones' care.

Our comments will focus on monitoring the effects of the implementation of the Patient Driven Groupings Model (PDGM), the request for information regarding access to home health aide services, support for family caregivers, aspects of home health quality reporting and value-based purchasing, health, and changes to the provider and supplier enrollment requirements related to hospice. Issues are generally in the order they appear in the proposed rule.

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 2024 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 18 percent from 9.86 in 2018 to 8.05 in 2022. 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 40 percent from 0.72 visits in 2018 to 0.43 visits in 2022, with over a 10 percent decrease from 2021 to 2022 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 over 83% in 2018 to nearly 89% in 2022. CMS also cites declines in skilled nursing, physical therapy, occupational therapy, and speech therapy in 2022 versus 2018.

The CMS data detailing these persistent downward trends and lack of data analysis by CMS indicating whether the appropriate level of home health care is being provided to beneficiaries raises real concerns. It is important for 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 (as discussed further below), which are an important part of the Medicare home health benefit. Critically, the home health benefit helps individuals receive services in their home, where most want to be, rather than institutional settings.

While 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, 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. The shift in payment incentives may encourage agencies to focus on serving post-hospital clients for short periods of time and discourage them from serving people with longer-term needs. We also believe that CMS should expand the data collected to include geographic, racial, ethnic, socioeconomic, sexual orientation and gender identifiers, highlighting whether disparities in telehealth usage vary in diverse populations. 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 Barriers to care must be removed to ensure equity in access to care.

We strongly urge CMS to ensure that all beneficiaries have access to the home health care they need and are eligible for, including home health aide visits. 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 real time. 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. In addition to the CMS-reported data on home health agency (HHA) utilization and cost measures, we suggest that additional data

¹ Jun Li, Mingyu Qi, and Rachel M. Werner. "Assessment of Receipt of the First Home Health Care Visit After Hospital Discharge Among Older Adults. *JAMA Network Open*. 2020;3(9):e2015470. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770143>

be collected that would more completely reflect the impact of the PDGM implementation. Such measures should be person-centered, to include patient reported outcomes and patient experience. Such measures should also include 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, 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 by key demographic characteristics such as age, race, ethnicity, and functional status.

AARP notes that some Medicare beneficiaries who need and are 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' eligibility to receive the services. We encourage CMS to educate physicians, advanced practice registered nurses, 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 urge provider education include required beneficiary outreach and education for family caregivers addressing inequities, delays, and disparities in access to home health services that some Medicare beneficiaries experience.

REQUEST FOR INFORMATION (RFI) FOR ACCESS TO HOME HEALTH AIDE SERVICES

AARP supports CMS' effort to learn more about access to home health aide services in its request for more information. We offer the following general concerns and recommendations of how CMS should move forward on this issue.

Hearing directly from Medicare beneficiaries and their family caregivers, as noted above, would provide important insights on access to Medicare home health and home health aide services. CMS should systematically examine approaches to measure and monitor any differences in adequate aide staffing by racial, ethnic, and socioeconomic factors, and take appropriate action to address any disparities. Moreover, we also urge CMS to use oversight and enforcement tools to ensure that beneficiaries receive the Medicare home health care they need and are eligible for, including home health aide visits. Beneficiaries who do not get the care they need may have unnecessary hospitalizations or other unnecessary institutional care or adverse health outcomes, along with detrimental effects on their well-being. Care provided by home health aides is an important part of the home health benefit.

AARP also recommends that CMS develop Medicare payment policies, as appropriate, for future payment years that would ensure access to necessary, high-quality care and reverse the downward trend in home health aides since the implementation of the PDGM. We recognize the persistence of this issue and the challenges associated for this workforce. Retention of home health aides and other similar workers is a serious issue, with a median turnover rate across the home care industry of almost 67 percent in 2017, which is related to a myriad of factors including inadequate compensation -- median rate of \$14.51 per hour in 2022 -- low quality

supervision, occupational safety injuries, adequate hours of work, training, and lack of career mobility.² We believe CMS plays an important role by providing appropriate payment, enforcement, and accountability to ensure sufficient aide staffing by HHAs. Payment should help ensure access to necessary and high-quality care for which Medicare beneficiaries are eligible, and HHAs should be held accountable for using the Medicare payment to provide high-quality, necessary, appropriate care, including access to home health aides.

We note research has found that Medicare beneficiary use of the Medicare home health benefit and home health visits decreased, while patient acuity increased from 2019 to 2020. Beneficiaries of color were less likely to have the assistance of caregivers, and a higher proportion of caregivers available to such beneficiaries needed more training to appropriately provide help. Hospitalizations were higher when the caregivers of the Latinx/Hispanic and Asian American beneficiaries with the highest acuity needed training.³

The potential gaps in continuity of care to beneficiaries from home health aide workforce issues places greater stress and strain on family caregivers assisting their loved ones. Sixty-one percent of family caregivers work full- or part-time while providing care, and nearly 4 in 10 caregivers find their caregiving situation highly stressful,⁴ which can be addressed in part by assistance from the paid workforce. With the home health aide workforce challenges (and even without them), AARP believes a critical component of any policy effort is to ensure that the home health care benefit appropriately incorporates and supports family caregivers voluntarily taking on their role. This helps ensure that the beneficiary is receiving continuity and high-quality care, and the services the beneficiary requires, as well as appropriately supporting the caregiver in their caregiving role. We note, however, that the unpaid labor of family caregivers should not be a substitute for appropriate and sufficient staffing of home health care aides providing necessary services.

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 because of the new unit of payment and elimination of therapy thresholds from the implementation of the PDGM.⁵ CMS proposes to apply only the -5.653 percent permanent adjustment to the 2024 base payment rate. CMS estimates that a temporary adjustment of approximately \$3.4 billion would be needed to reconcile retrospective overpayments in 2020, 2021, and 2022. CMS notes that applying the full permanent and temporary adjustment would result in a significant negative adjustment in a single year.

² Spetz J, Stone RI, Chapman SA, Bryant N. Home And Community-Based Workforce For Patients With Serious Illness Requires Support To Meet Growing Needs. *Health Affairs* (Millwood). 2019 Jun;38(6):902-909. doi: 10.1377/hlthaff.2019.00021. PMID: 31158024. Median wage data from 2022 is from <https://www.bls.gov/oes/current/oes311120.htm>.

³ Melissa Morley et al., *Changes in Medicare Home Health Use During COVID-19 and the Implications for Health Equity and Caregiver Availability* (Commonwealth Fund, June 2022)

⁴ AARP and National Alliance for Caregiving. *Caregiving in the United States 2020*. Washington, DC: AARP. May 2020. <https://doi.org/10.26419/ppi.00103.001>

⁵ Sections 1895(b)(3)(A)(iv) and 1895(b)(3)(D) of the Social Security Act

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

HOME HEALTH QUALITY REPORTING PROGRAM (HH QRP)

Replacement in the HH QRP Measures Set of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) Measure with the Discharge Function Score (DC Function) Measure

CMS is proposing adoption of the DC Function measure in both the HH QRP and Expanded Home Health Value-Based Purchasing (HHVBP) Model. The measure is a functional measure for use across all post-acute care (PAC) settings that is calculated using standardized patient assessment data from the Outcome and Assessment Information Set (OASIS). This measure would replace the Application of Functional Assessment/Care Plan measure, which CMS is proposing to remove from the HH QRP on the basis that it is topped out. The DC Function measure would incorporate both the domains of self-care and mobility.

Many home health patients begin their episode of care with functional debility. Maintaining and/or improving functional ability is a foundational goal of post-acute care for home health patients, their caregivers, and home health agencies (HHAs). AARP believes that measures of functional status have value for provider performance improvement and for informed decision making by individuals and their families. AARP therefore supports continued work by CMS focused on self-care and mobility measures.

AARP acknowledges the benefit of a functional measure that uses a set of cross-setting assessment items. We agree this facilitates data collection, quality measurement, and outcome comparison across PAC settings. We believe that consistency across settings where appropriate aides in the familiarity, transparency, understandability, and usability of information, which is essential in the decision-making process and continuum of care for home health patients and their caregivers. At the same time, AARP acknowledges that there are unique factors applicable to each individual setting that must be considered when adopting measures in a quality reporting program.

AARP also acknowledges that when a measure is considered “topped out”, that performance on the measure (such as the Application of Functional Assessment/Care Plan measure) no longer provides for a meaningful distinction in performance and therefore is not providing useful information to assist decision making by individuals and their families. Therefore, AARP supports replacing such a measure with one that does provide for a meaningful distinction in performance of HHAs to optimize the transparency of comparative information available to individuals and their caregivers.

In considering a measure for functional status for adoption in the HH QRP or HHVBP – and because individuals and families place high value on optimal functional outcomes – we recommend that the measure have beneficiary and family caregiver input (e.g., as members or advisors to the Technical Expert Panel) and be designed in a way that facilitates easily understood public reporting of results on Care Compare. We also suggest the use of beneficiary and family caregiver focus groups or similar testing of potential measures to provide valuable feedback before measures are finalized. We note and appreciate that CMS held a Patient and Family Engagement Listening Session to seek and consider beneficiary and family caregiver feedback on the DC Function measure. We suggest that CMS examine measure(s) that would capture both maintenance and improvement in functional status.

Addition to the HH QRP Measures Set of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) Measure

CMS is proposing adoption of the Patient/Resident COVID-19 Vaccine measure beginning with the 2025 HH QRP. The measure is an assessment-based process measure that reports the percent of the total number of home health patients who are up to date with their COVID-19 vaccination, per the latest guidance of the Centers for Disease Control and Prevention.

Recognizing the expiration of the public health emergency declaration on May 11, 2023, AARP believes that adherence to infection prevention and control measures is essential to the health, safety, and well-being of home health patients, their family caregivers, and the home health care workers providing their care. COVID-19 vaccinations and boosters have been effective tools in preventing the severe consequences of COVID-19. To this end, AARP believes the measure would be a relevant and valuable addition to the HH QRP measure set and supports its adoption. This measure would provide valuable information to prospective and current home health patients and their family caregivers in their decision-making process. We also acknowledge that consent of the patient is critical and that even after education, some individuals may still decline vaccination. The intent of the measure is not to punish agency staff or HHAs if they encounter a large population of patients who decline vaccination.

Access to transparent, complete, and easily understandable information is an essential tool for home health patients and their caregivers in support of informed decision-making. AARP supports publicly reporting results on Care Compare, while protecting beneficiary privacy, to aid beneficiaries and families in selecting an HHA. AARP continues to emphasize the importance of including information highlighting measures on Care Compare in a transparent and easily understandable manner. It is vital that home health patients and family caregivers understand and can interpret what data is being represented. We appreciate CMS' attention to this in proposing the measure and seeking input from a focus group of patient and family/caregiver advocates.

CMS noted in the preamble of the proposed rule the disparity in vaccination rates as well as in receipt of boosters. We urge that reported data include demographic information to highlight such potential disparities similar to those already uncovered. To help assess and address health equity gaps, strong consideration should also be given to providing results to HHAs that are

stratified for race, ethnicity, and other social risk factors based on information submitted by HHAs.

As we have raised previously, AARP remains concerned that CMS is no longer planning to require COVID-19 vaccination for staff of Medicare and Medicaid-certified providers and suppliers. Vaccination of home health patients and home health care workers has been key to improved COVID-19 outcomes among such patients. We urge CMS to revisit this issue moving forward.

Public Reporting of the Transfer of Health Information to the Patient Post-Acute Care (TOH-Patient) and Transfer of Health Information to the Provider Post-Acute Care (TOH-Provider) Measures

The TOH-Patient and TOH-Provider measures track the transfer of vital information (i.e., current, reconciled, medication lists) during transitions of beneficiaries between transferring and receiving providers or home. CMS previously adopted these two measures, but the compliance dates for collecting and reporting were delayed due to the COVID-19 public health emergency. CMS is proposing to begin public display of data for the measures with the January 2025 refresh of Care Compare (or as soon as technically feasible) based on 4 rolling quarters, initially using discharges from April 1, 2023, through March 31, 2024.

AARP acknowledges the importance of such measures and supports prompt implementation. However, we continue to emphasize the need for CMS to take steps to ensure that the current and accurate medication list is provided to the home health patient and family/caregivers (with patient consent) regardless of when or where the patient is transferred.

Also, family caregivers often have a vital role in the home health care of Medicare beneficiaries. They are often involved in assisting the beneficiary with their medications. It follows that the transfer of the medication list to such family caregivers (in addition to the beneficiary) is often integral in the care continuum. We continue to recommend that the data element for the TOH-Patient measure be clear that if a beneficiary has a family caregiver that individual should receive the medication list if the beneficiary and family caregiver consent, even if it is also provided to the patient. In addition, for the TOH-Patient measure, it is important that the home health patient and family caregiver be given an opportunity to ask questions about the medication list to ensure they understand it.

Health Equity Update

CMS may consider in the future whether to adopt health equity measures used in other settings into the HH QRP, and specifically mentions considering adding into the HH QRP the social determinants of health data items used in the acute care setting. The social determinants of health data for post-acute care providers under the IMPACT Act, which are collected as standardized patient assessment data elements (SPADES) on the OASIS, are different from social determinants of health (SDOH) data used in the acute care health equity quality measures. The data collected on SPADES include assessing health literacy, social isolation, transportation problems, preferred language (including need or want of an interpreter), race, and ethnicity,

whereas the social determinants of health domains for screening used in the acute care settings include housing instability, food instability, transportation needs, utility difficulties, and interpersonal safety.

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. In furtherance of those goals, AARP generally supports broadening the scope of social determinants of health data and social risk factors considered that have effects on patient outcomes, including by making such measures consistent among settings where it is appropriate and feasible (including feasibility to collect and apply the information).

In considering additional measures for inclusion in the HH QRP, AARP strongly emphasizes the importance of developing one or more measures that capture information about family caregiver status, caregiver involvement in a beneficiary's care, and support provided to the caregiver(s). 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. We, therefore, 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 are very pleased to note and strongly support the proposal in the 2024 Medicare physician fee schedule that includes proposed changes to pay for training for family caregivers in certain circumstances. AARP's recommendation here is in line with that proposal, which acknowledges that caregivers play a key role in the development and implementation of treatment plans.

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. It also provides an opportunity to identify and provide needed support for a family caregiver, such as education and training, especially around care transitions.

Such measures relating to family caregivers address a means for identifying social risk factor considerations. The absence of an identifiable caregiver 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 respected during care delivery by HHA staff members.

CMS also notes that some of its future health equity efforts will be through notice and comment rulemaking and some efforts through sub-regulatory actions. 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 s

upport this approach, which keeps beneficiaries and all other interested parties informed and provides for transparency and accountability, urging 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.

RFI on Guiding Principles for Selecting and Prioritizing HH QRP Quality Measures and Concepts under Consideration for Future Years

The proposed rule identifies guiding principles for inclusion and maintenance of measures in the future HH QRP measure set. The principles intend for the measures to be meaningful to beneficiaries and family caregivers, not impose undue burden on HHAs, align with PAC program goals, and be readily operationalized. CMS seeks information on these principles and existing gaps in the HH QRP measure set for purposes of addressing those gaps. AARP supports the principles of the established National Quality Strategy (NQS) – promoting a high-value health care system advancing quality outcomes, safety, equity, and accessibility for all individuals – which inform the analysis for inclusion in the HH QRP measure set. AARP strongly recommends as a guiding principle that only measures for which data elements are clearly defined, valid, and well standardized be prioritized for the HH QRP measure set. We also strongly encourage CMS to give high priority to measures developed in response to issues identified through review and analysis of beneficiary and family input. Generally, we support measures that are meaningful to home health patients and their family caregivers, and which emphasize such patients’ reported outcomes and support shared decision-making and health equity. We urge that guiding principles include the collection of demographic data, taking into account beneficiary and family caregiver input, and emphasizing measures that result in transparent information that is informative to beneficiaries and caregivers.

CMS specifically asks if there are existing measurement gaps in the HH QRP that were not identified by the agency. AARP believes there is an existing measurement gap related to support for family caregivers, including caregiver status. As we have mentioned, AARP strongly supports the addition of Caregiver Status to the list of SPADEs required for reporting by HHAs and other PAC providers. This data point would identify whether the beneficiary has a family caregiver (who may or may not be the next of kin) and identify that individual to the HHA, including contact information (with consent of the resident and the family caregiver). Family caregivers can impact beneficiary’s care, outcomes, and quality of life. Their identification facilitates engagement, communication, and coordination with the caregiver, as well as the provision of caregiver support, as appropriate.

EXPANDED HHVBP MODEL

Changes to the Measures Set

CMS is proposing to modify the Expanded HHVBP Model measures set by removing five measures and adding three measures as replacements to better align the measures set with the HH QRP measures set as well as with other PAC setting measures sets. Generally, AARP supports alignment of measures across settings, especially to the extent such alignment promotes transparency, understanding, and usability of the information provided by such measures to assist beneficiaries and their caregivers make informed decisions in their care continuum. We caution, though, that measure replacements should not prioritize alignment of measures across settings over the value the individual measure brings to providing complete and comprehensive data. To that end, we encourage that before any measure replacement is adopted, CMS conducts a detailed comparison of the measure that would be removed and the measure that would be adopted as a replacement to ensure the replacement measure provides at least the scope and granularity of information as the measure being replaced, especially in the case where the measure domain of the proposal would be affected (such as when a claims-based measure is proposed to replace an OASIS-based measure).

Health Equity Update

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. We acknowledge the desire to provide HHAs with time to learn the Expanded HHVBP model. However, we believe that learning process can occur simultaneously with CMS actively continuing efforts to further health equity. We therefore strongly encourage CMS to continue to pursue ways to incentivize the achievement of health equity in the HHVBP model without delay.

CHANGES TO THE PROVIDER AND SUPPLIER ENROLLMENT REQUIREMENTS

Hospice Specific Provisions

AARP is supportive of the provider and supplier enrollment requirements related to hospice and CMS' enhanced provisions to detect parties potentially posing a risk of fraud, waste, or abuse. We support the CMS proposal, for example, to move initially enrolling hospices and those submitting applications to report any new owners into the "high" level of categorical screening; revalidating hospices would be subject to moderate risk-level screening. This would require criminal background checks on all hospice or contracted employees who have direct patient contact or access to patient records.

AARP is also supportive of the additional provider enrollment steps CMS is taking to address hospice ownership and program integrity. This proposed revision requires the provider/supplier/hospice to explicitly identify whether a listed organizational owner/manager does or does not fall within the categories of entities listed on the application with "private-equity

company” and “real estate investment trust” being added to the list of organization types that includes holding company and investment firm.

AARP applauds these efforts, but we believe these are only the first steps in ensuring that Medicare beneficiaries receive quality care and that more needs to be done to further strengthen program integrity efforts and increase transparency. As we have indicated previously, ownership trends in the hospice industry can impact the care that Medicare beneficiaries receive. A recent analysis found that family caregivers of hospice patients “...reported substantially worse care experiences in for-profit than in not-for-profit hospices; however, there was variation in reported experiences among both types of hospices.”⁶

Public reporting of hospice ownership is important. We encourage CMS to collect data on ownership and quality, use and analyze that data, and make it available in an easy-to-understand format for consumers and their families seeking hospice care to help them select a hospice provider that is right for them and will provide quality care.

Consistent with our recent [comments](#) to CMS on expansion of ownership transparency in the nursing home sector in response to CMS-6084-P,⁷ many of these efforts could be applied to the hospice sector as well. Here are some principles or concepts from these comments that could be applied to the hospice sector:

- CMS should require that ownership information be true, correct, and complete and that information be easily accessible for beneficiaries receiving hospice, beneficiaries considering hospice, their family caregivers, and the public. We believe that self-reported information should be audited for accuracy and that reporters of inaccurate data should face appropriate enforcement action.
- CMS should take a more proactive role in monitoring hospices to encourage positive change. This should be done in a timely manner to improve quality, using ownership data, Hospice Cost Report Data, clinical quality metrics, and other appropriate data to understand the ongoing performance of individual hospices and large groups connected by common ownership.
- CMS also should require disclosure of owners within the parent company to reflect the complexity of ownership, increase transparency, and be able to hold accountable the parent companies of hospices.

CMS should continue its efforts to make ownership data for all Medicare-certified hospices publicly available. We are supportive of CMS’ recent announcement that it would release ownership data on more than 6,000 hospices as we believe this is an important step forward to promote and increase transparency of ownership information. We are concerned about the accuracy and accountability of the reported data and urge CMS to consider ways to ensure its accuracy. AARP also urges CMS to add ownership information about hospices that is already available on data.cms.gov to Care Compare, which would be helpful to consumers.

⁶ See Anhang Price R, Parast L, Elliott MN, et al. Association of Hospice Profit Status With Family Caregivers’ Reported Care Experiences. *JAMA Intern Med.* 2023;183(4):311–318. doi:10.1001/jamainternmed.2022.7076

⁷ Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities

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 on our Government Affairs staff at rrichards@aarp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a long horizontal flourish extending to the right.

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs