C-TAC
COALITION TO TRANSFORM ADVANCED CARE

1299 Pennsylvania Avenue NW
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November 19, 2018

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

Dear Ms. Verma,

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 advanced illness.

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those living with advanced 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 140 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 advanced illness care in the U.S.

C-TAC's definition of advanced illness is when one or more conditions becomes serious enough that general health and functioning begin to decline, treatment may no longer lead to preferred outcomes, and care oriented toward comfort may take precedence over attempts to cure – a process that extends to the end of life and that for some individuals and their families may lead to transition to hospice.

We have several comments on this proposed rule as various sections will impact the care of those with advanced illness. Specifically:

Proposed Hospice Changes

<u>Hospice Requirements for Medication Management</u>

- *Removing the requirement for a medication expert*- We have some concerns about this proposed change as it could undermine patient safety. Given the realities of the opioid epidemic, we feel it is important to ensure that hospices, which frequently use opioids for symptom management, have adequate expertise in this area. Also, while it may be true that there are likely others on the hospice team who have knowledge of medication management, that may not always be the case. Smaller or

newer hospices working with less experienced staff may also lack the necessary depth of medication knowledge. Finally, since medication reconciliation and symptom management are separately required by hospice Conditions of Participation, it is difficult to see how removing the medication expert provision will really reduce administrative burden on them. We have spoken with some of our hospice members and they feel having a medication expert is an appropriate administrative responsibility given patient safety concerns and therefore not something they would want to no longer be required to have.

- *Providing medication information vs. requiring paper copies of medication policies and procedures*- We are in favor of this proposed change since it will likely better meet the information needs of patients and families and provide more personalized care. However, in talking with our hospice colleagues, they point out that the recent passage of H. R. 6, the SUPPORT for Patients and Communities Act, which outlines changes in the disposal of unused controlled substances, also specifies that the hospice must provide a written copy of the hospice's policies and procedures concerning medication management. We therefore encourage CMS to provide guidance on what information should be provided to patients and families to be in compliance with the new law.

<u>Allowing negotiation about responsibility for orienting Skilled Nursing Facility (SNF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) about hospice</u>

We support this change as it is impractical to coordinate hospice orientation of facility staff when several different hospices serve a SNF or ICF/IID. In order to best reduce administrative burden, we suggest that the final rule allow hospices to renegotiate changes to their contracts over time in order to avoid the added administrative burden of having to do so all at once.

However, the bigger issue is that there are significant opportunities to improve the quality of end-of-life care in such facilities as not all residents there receive hospice. Therefore, primary end-of-life care skills should be required of facility staff. We realize this would require a separate change in the regulations for SNFs and ICF/IIDs, but it places the orientation responsibility on such facilities, where it more appropriately belongs.

<u>Hospice aide training and competency requirements vis a vis state requirements</u>
We are in favor of this proposed change although our concern is that there is likely large variability across states in regard to aide training. Because of that, there may need to be a federal floor for hospice aide training requirements that states could surpass, but not go below.

<u>Reducing the frequency of required hospice annual emergency preparedness testing</u>
We do not support this proposed change. Natural disasters and emergencies are increasing, as is noted in the recently proposed Medicare Advantage rule for 2020[i]. Our discussions with hospices suggest many think they need to bolster their emergency preparedness, not

reduce it.

Proposed Hospital Changes

Reducing Hospital Requirements for Comprehensive Medical History and Physical Examinations

While we appreciate the effort to reduce unnecessary clinical and charting work, we feel that this proposed change will not serve those beneficiaries with advanced illness well. A third of the elderly, for instance, have surgery in the last year of life[ii] and, due to their medical complexity, even simple procedures are often not simple for them. In talking to our hospital system members, we have heard that a comprehensive medical history and physical examination can result in the discovery of vitally important information, allowing clinicians to make necessary changes in patient-specific surgical plans. *We therefore recommend that the rule be revised to note that the assessment be consistent with the patient's situation, medical complexity, and the proposed procedure and, in the case of advanced illness, err on the side of more, rather than less, comprehensiveness*.

Hospital Quality Assessment and Performance Improvement Program (QAPI Program) on a system-wide basis

We support this proposed change as it recognizes that hospitals within large hospital systems would benefit from adopting those system-wide QAPI programs as opposed to having to have their own individual ones. This could not only reduce administrative burden but improve quality by allowing for more robust and standardized QAPI programs.

Proposed Home Health Changes

Home Health Agency (HHA) Requirements for Providing Patients with Copies of Clinical Records

We support the proposed change to provide patients with copies of their clinical records within four business days, as opposed to the next visit. We do suggest, however, that in the interest of personalized care, the response time be appropriate to the urgency of the patient's issue and reason for requesting such copies and be no longer than four business days from that request.

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 443-742-8872 or mgrant@thectac.org.

Sincerely,

Marian Grant

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[i] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23599.pdf?utm_campaign=pi%20subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email

[ii] https://www.ncbi.nlm.nih.gov/pubmed/21982520