On behalf of the National Alliance for Care at Home, the unified voice for providers delivering high-quality, person-centered healthcare to individuals wherever they call home, we appreciate the opportunity to comment on the Advance Care Planning (ACP) quality measure under consideration. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide. We applaud the Centers for Medicare & Medicaid Services' (CMS) ongoing commitment to quality of care and advancing person-centered care.

We strongly support the intent of the ACP measure to promote advance care planning conversations and ensure patient preferences are documented and accessible across care settings. Advance care planning is fundamental to person-centered care, and our members are deeply committed to honoring patient wishes. However, we have several concerns regarding the measure's scope, feasibility, and potential unintended consequences.

The measure specifications are focused on hospital-based documentation; however the measure is under consideration for numerous quality reporting programs, including various inpatient and outpatient hospital settings as well as post-acute care settings. It is unclear how the measure would be applied to post-acute care providers, including home health agencies. Second-hand reporting from a provider other than the hospital from which the patient is discharged compromises the integrity of the data reported. Furthermore, the non-hospital entity may not have access to the hospital documentation and/or advance directive document. Lack of access to hospital records is an ongoing concern for post-acute care providers as it compromises coordination of care.

As written, the ACP measure focuses on whether an advance directive was completed. Revising the scope of the ACP measure to capture whether an advance directive is present on admission and, if not, to measure whether a discussion on advance care planning was offered and occurred prior to discharge may be better aligned with the intent of the ACP measure. Such a revision could support a cross-setting process measure. We noted that the ACP measure is not under consideration for the Hospice Quality Reporting Program (HQRP). This may be because the HQRP currently includes a section titled "Preferences" on the Hospice Outcome & Patient Evaluation tool (HOPE) with four questions that are related to ACP. These four questions capture data on whether the patient/responsible party was asked about their preference regarding the use of cardio-pulmonary resuscitation (CPR), life-sustaining treatments other than CPR, hospitalization preference and spiritual/existential concerns. These or similar questions could be considered for an ACP process measure.

It is important that advance care planning be discussed and that patients be well informed about advance directives and the options available to them. Studies show that having been asked about advance directives by medical staff, legal staff, or family and friends increases the likelihood that patients will possess an advance directive[1]. The Alliance and its members recommend a phased approach to incorporating ACP into CMS quality programs that begins with a discussion of patient preferences and options available to them (if an advance directive has not been completed). This type of process measure could be appropriately applied across all care settings. Relative to care

[1] Lauren J Van Scoy, Judie Howrylak, Anhthu Nguyen, Melodie Chen, Michael Sherman Family structure, experiences with end-of-life decision making, and who asked about advance directives impacts advance directive completion rates J Palliat Med. 2014 Oct;17(10):1099-106.doi: 10.1089/jpm.2014.0033. Epub 2014 Jul 7

settings, the Alliance received feedback from some members that primary care practices are the most appropriate health care delivery setting for ACP discussions. Primary care providers are usually most knowledgeable about a patient's overall health status and have established rapport with patients, which may better support ACP discussion and decisions. Primary care practitioners are also able to bill for ACP discussions. These discussions do require human and financial resources that are not currently reimbursed in all sites of service, nor for all providers. Specifically, home health agencies do not have a path to billing for these discussions. Moreover, the United States is experiencing a significant staffing crisis, which must be taken into account when considering how an ACP measure would be implemented. An unfunded requirement that adds burden to the existing workforce challenges may not be properly implemented.

Medical social workers and palliative care teams are often utilized in hospital settings for ACP discussions. Home health agencies do not have these dedicated staff. To be Medicare certified, home health agencies must provide nursing services, but are not required to provide medical social work services. The responsibility for ACP discussions and documentation would likely default to home health nurses who are already stretched thin. They may not have the training and experience necessary for ACP discussions with all types of patients, adding to the responsibility and financial burden of the home health agency that employs them. Home health agencies are currently experiencing the greatest cuts to their Medicare payment, resulting in closures of some agencies.

The 18-year age threshold and broad application of the ACP measure to all individuals this age and above who are hospitalized may not align with clinical appropriateness for advance care planning conversations. The Alliance recommends consideration of a higher age threshold and risk stratification approach that targets patients with serious illness, chronic conditions, or high healthcare utilization.

Also, if nearly every care setting is expected to gather data about advance directives and offer ACP discussions, patients and their families may become "fatigued" with this interaction and refuse an ACP discussion. Worse yet, they may simply check a box or sign a document under duress. Being routinely and repeatedly subjected to an ACP discussion and/or pressured to make a decision or complete an advance directive dilutes the importance and value of these types of discussions.

The specific documentation requirements that would constitute acceptable ACP documents, per MUC2025-020, include POLST/MOLST forms. It is important to note that not all states have such forms, and for those that do, there are variations of these types of forms.

There are no exclusions or exceptions for the numerator and denominator of MUC2025-020. The Alliance strongly recommends that if the measure is approved for use by CMS in quality reporting programs that it be revised to account for patients who decline ACP discussions as well as those that do not have the capacity to have a discussion or make an ACP decision. We also encourage stratifying results and examining potential disparities in ACP completion across demographic groups, as research indicates significant variations based on race, ethnicity, language, health literacy, and socioeconomic factors.

In support of truly coordinated care, seamless access to ACP documentation is essential for home health agencies and other providers. There should be standardized ACP documentation formats to facilitate electronic sharing across settings.

Home health agencies and hospices are natural partners in advancing the important work of person-centered care and ACP. We stand ready to collaborate with CMS and hospital partners to ensure seamless care transitions that honor patient preferences. Our members are committed to high-quality, patient-centered care and believe that properly designed quality measures can drive meaningful improvements in advance care planning. Thank you for considering these comments.