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June 25, 2018

Administrator Seema Verma
Centers for Medicare and Medicaid Services
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1694-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates, and Other Issues

Dear Administrator Verma:

AARP appreciates the opportunity to comment on the Medicare inpatient prospective payment systems proposed rule, and we focus our comment in this letter to quality reporting and price transparency. AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. Territories, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as health care, employment and income security, retirement planning, affordable utilities, and protection from financial abuse.

Social Risk Factors

As was the case in FY 2018 proposed rule, several sections of the proposed FY 19 rule discuss the inclusion and modification of risk factors related to a Medicare beneficiaries' socio-economic status (SES) to determine provider reimbursement for Medicare services. Specifically, we continue to be concerned with utilization of these factors in the following programs:

- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing Program
- Hospital-Acquired Condition Reduction Program
- Hospital Inpatient Quality Reporting Program

AARP continues to believe that this approach does not address the underlying disparities that are often associated with poor health outcomes. This approach will mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations. Higher payments for treating high-risk individuals encourages providers to take on these individuals as patients; but it does not encourage providers to improve outcomes or quality. We reiterate our concerns that these types of adjustment create perverse incentives for poor performers to continue with the status quo and for high performers to retreat from their efforts to address disparities in high SES populations.

Proposed New Removal Factor for Previously Adopted Hospital Value-Based Purchasing Program Measures

We oppose the adoption of the proposed new, eighth factor for evaluating whether to remove a previously adopted quality measure. The proposed new factor is defined as “the costs associated with a measure outweigh the benefits of its continued use in the program.” As described in the proposed rule, a variety of different costs could be considered under this criterion. While we understand the goal of ensuring quality measures yield meaningful benefits, we do not support using the proposed new criteria to potentially remove an existing measure. The existing seven factors are sufficient to achieve this goal. With respect to the proposed new factor, 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 born by providers – these are not equivalent. The proposed new factor would open the door for providers to argue for dropping a measure they do not want to collect or report for various reasons (such as that it would raise their costs to avoid performing poorly on it), but which is important to beneficiary outcomes.

Price Transparency

AARP believes individuals should know the financial costs of the health care they receive, and that price information can be a useful tool for consumers to make informed decisions about their care. A hospital’s chargemaster or listed price menu is not a particularly useful source of information, however, because it does not reflect the person’s actual out-of-pocket costs. We recommend that CMS require hospitals to post their hospital-specific Medicare rates and corresponding expected beneficiary out-of-pocket coinsurance amounts. This would offer more meaningful price transparency than hospital “standard charges”, which Medicare does not pay.

Request for Information on Promoting Electronic Interoperability

AARP supports the continued promotion of electronic health information exchange and interoperability that is aimed at improving patient care by making medical records readily available to providers, patients, and their family caregivers, as appropriate. Electronic data exchange among hospitals, physicians, hospices, skilled nursing

facilities (SNFs), and other post-acute care providers is especially important during care transitions when information relevant to the individual's next phase of care may be lost.

Having information useful to manage their own care when they are not directly interacting with their care team (e.g., after an encounter) is a critical support that individuals (and family caregivers, as appropriate) need, regardless of their condition or health status. Access to information electronically, such as discharge summaries and test results, greatly enhances opportunities to engage in one's own care. By sharing information with providers, caregivers, or other members of the individual's care team, it can help them better coordinate and manage their care needs. Under HIPAA privacy rules, health care providers must give individuals access, upon request, to the protected health information about them. People with the capacity to access their medical records and personal health information through patient portals or other electronic means should have the right and ability to do so without undue burden, as for many this can be easier than requesting and managing printed information. However, while AARP fully supports moving forward expeditiously on improved electronic access, many people will still need or prefer to access printed copies of their medical records or discharge/transfer summaries, or receive them by mail or fax, and CMS should ensure that this right continues. Not everyone has the technology for electronic access, including many older Americans.

AARP appreciates this opportunity to provide comments on this proposed rule, and commends CMS for its continued commitment to improving quality of care. If you have questions, please contact Andrew Scholnick of our Government Affairs staff, at ascholnick@aarp.org or 202-434-3770.

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 & Legislative Policy Director
Government Affairs