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June 21, 2018

Administrator Seema Verma  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1692-P  
P.O. Box 8010  
Baltimore, MD 21244-1850

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

Re: Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update  
and Hospice Quality Reporting Requirements

Dear Administrator Verma:

AARP appreciates the opportunity to comment on the FY 2019 hospice proposed rule. We are pleased that the proposed rule incorporates the Bipartisan Budget Act (P.L. 115-123) requirement that effective January 1, 2019, physician assistants (PAs) be recognized as designated hospice attending physicians. PAs have an important role in providing hospice care, including providing hospice care in rural areas, and we believe this provision will increase access to hospice services.

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 healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

### **Public Reporting of Additional Quality Measures on Hospice Compare**

AARP also appreciates CMS' commitment to make hospice quality measure data available to the public but is concerned that CMS proposes to use sub-regulatory means to announce to providers the public reporting of additional quality measures on Hospice Compare. The Hospice Compare web site only began providing quality

measure data in August 2017. Hospice Compare initially reported 7 Hospice Item Set (HIS) Measures; in February 2018, the CAHPS Hospice Survey measures were added. CMS states that sub-regulatory notice would facilitate public reporting of quality data in an “expeditious, yet still transparent manner” as soon as it meets the minimum standards for public reporting.

AARP recognizes the importance of providing quality data in a timely manner but we are concerned that the sub-regulatory notice is not transparent to stakeholders, including beneficiaries and their family caregivers. We do not think it is sufficient to determine measures meet the National Quality Forum (NQF) standards for reliability, validity, and reporting before public reporting. Providing notice to the public through rulemaking allows CMS to obtain comments, including concerns, directly from the consumers using the information on Hospice Compare to evaluate hospice providers. Selecting a hospice provider is an important decision, often associated with stress, and CMS needs to ensure the public has the ability to both provide feedback about which measures are displayed and also ensure the public is informed about the addition of new measures.

### **Proposed New Removal Factor for Previously Adopted Hospice Quality Reporting 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 “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 that 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.

### **Request for Information on Promoting Interoperability Through CMS Patient Health and Safety Requirements for Hospitals and Other Providers**

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, and other post-acute care providers is especially important during care transitions when maintaining access to information relevant to the individual’s next phase of care is essential.

For individuals (and family caregivers, as appropriate) 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 everyone needs, 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, and to help them to better coordinate and manage their care needs. Under HIPAA privacy rules, health care providers must give individuals access, upon request, to their protected health information. 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 printed copies of their medical records or discharge/transfer summaries, and to have access by mail or fax, and CMS should ensure that this right continues. Not everyone has the technology for electronic access, and this is particularly true for many older Americans.

Use of hospice conditions of participation aimed to result in greater provider participation in electronic health information exchange should be considered carefully and should be based on a realistic assessment of costs to providers and reasonable timeframes for adoption. Given the potential to reduce Medicare beneficiary access to care, hospice conditions of participation may not be the best approach because the consequences of failure by a provider to meet the standard could be exclusion from the program. If this type of mandate is chosen, the specific requirements should be attainable by providers making a good faith effort and perhaps phased in over time. Hospices have not had the opportunity to participate in the financial incentives offered by what is now the Medicare and Medicaid Promoting Interoperability Program. Special circumstances of rural and low-volume providers should be taken into account. If imposed requirements are unattainable, the policy would not only fail to achieve the goal of improving electronic health information exchange, but could result in other unintended consequences.

AARP appreciates the opportunity to comment on this important hospice proposed rule and CMS' consideration of our comments. If you have questions, please contact me or Rhonda Richards ([r-richards@aarp.org](mailto:r-richards@aarp.org)) on our Government Affairs staff at 202-434-3770.

Sincerely,



David Certner  
Legislative Counsel & Legislative Policy Director  
Government Affairs