June 17, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1771-P Medicare Hospital Inpatient Prospective Payment Systems

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to comment on proposed changes to the Medicare Hospital Inpatient Prospective Payment System for fiscal year 2023. We applaud the Centers for Medicare & Medicaid Services’ commitment to health equity and access for the more than 64 million Medicare beneficiaries. Our comments focus on measuring health care quality disparities and proposed changes to the data collection and reporting requirements for hospitals.

Hospital-Acquired Condition Reduction Program

CMS’ proposal would suppress public reporting of vital data on patient safety in U.S. hospitals. Specifically, CMS proposes to not calculate, report to hospitals, or publicly report results for the CMS Patient Safety and Adverse Events Composite (or PSI 90) – a composite measure based on rates of harm from avoidable, dangerous surgical and medical complications experienced by tens of thousands of hospital patients each year. This important measure of each hospital’s patient safety and quality is currently included in CMS’ Care Compare tool available to consumers. In addition, CMS’ proposal to apply a “measure suppression factor” in the future would potentially suppress additional measures without the rulemaking process that allows for public review and comment.

AARP opposes both of these proposals and urges CMS to continue the collection and reporting of data on complications experienced by patients and other measures of hospital quality and consumer experiences. These data must continue to be made publicly available in formats that consumers can easily obtain and use, such as the PSI 90 measure and the Care Compare tool. If the PSI 90 measure is suppressed, consumers will not have this essential information on hospital quality when making vital decisions affecting their health and lives, and those of their family members. Withholding such important and needed information will inhibit quality improvement and be harmful to the public. Similarly, any future considerations of suppressing measures that are now publicly reported should be subject to the rulemaking process of public review and comment.

Measuring Healthcare Quality Disparities Across CMS Quality Programs

CMS seeks stakeholder input on the overarching principles that should guide its measurement of health care quality disparities across various programs. AARP applauds CMS’ commitment to achieving equity
in health care outcomes for seniors by supporting quality improvement activities that reduce health disparities and promote health care provider accountability for health care disparities. Quality improvement activities, through public reporting, also allow seniors and their family members to make more informed health care decisions and health care provider choices. AARP supports CMS’ intention to measure, report, and incent equity within Medicare to ensure all seniors have access to affordable, high-quality health care and equitable outcomes, regardless of age, income, race, ethnicity, disability status, gender, geography, sexual orientation or gender identity.

AARP agrees that information collected should be actionable for health care providers to address disparities in care and that stratifying quality measures to showcase disparities in outcome or quality will drive improvement in care. AARP supports CMS’ use of within-provider and across-provider stratification as both provide important information for health care providers, patients, and their families. The former showcases disparities in patient care among the provider’s patient population and presents an opportunity for internal innovation and quality improvement towards more equitable care. The latter presents provider to provider comparisons, which is helpful benchmarking for health care providers improvement efforts and, more importantly, is critical for patient engagement and informed decision-making.

Relatedly, CMS seeks comments on the principles to be considered for the selection of social risk factors and demographic data for measuring disparities. To date, CMS has used dual status as an indicator of financial risk for stratification. Dual status, however, does not reflect many other social risk factors that have equal or even greater effect on patient outcomes, and it does not reflect bias and discrimination that some populations may encounter which affect access, care, and outcomes. The types of factors used for stratification should align with the goals of stratification. As an example, racial and ethnic disparities in immunization rates for many preventable diseases are large and persistent, and stratification by race/ethnicity of process measures aimed at improving immunization rates could support efforts to close that disparities gap. Whereas, if social supports or transportation are identified as social risk factors primarily affecting a particular outcome, then those should be used for stratification. As a principle, CMS should identify the goals of measuring disparities and let that guide the stratification indicator.

As CMS notes, self-reported social risk factor measures are the gold standard; in their absence, CMS should be cautious using area-based indicators or imputation techniques, and it should not assign these constructed indicators to individual patients. AARP appreciates the nascent state of self-reported social risk factor and demographic data; that said, other initiatives, Z-codes, and a growing list of Gravity-defined terminology for social risk factors should be supported and incentivized for use. As observed with Z-codes, take-up will be slow unless there is a reason for providers and clinicians to collect social risk and demographic information. A commitment to public reporting and stratification could provide that incentive.

AARP urges CMS to report all stratified measure results when adopted into quality reporting and not hold them confidentially until health care providers begin to implement improvements. Unlike newly adopted measures, stratification factors are less complicated constructs than performance measures, and an indicator is likely used with different quality measures. Transparency is a significant driver of improvement and far more effective (as years of public reporting have shown) at changing behavior. Making meaningful progress in reducing disparities should include public reporting of stratified measures. If health care providers are interested in showcasing efforts to reduce disparities, one approach
might be to make visible their performance improvements over time, which could be presented in a number of different ways that do not add to provider burden.

AARP agrees it is important to report stratified measures because stratification provides critical information within an accountability framework. Whether an overall measure should be reported alongside stratified measures raises difficult questions and could lead to unintended negative consequences that do not align with the goals of reducing disparities. For instance, if both stratified measures and overall measures are reported, how will those measures be presented in public reporting and will having two sets of measures create confusion among patients and families or lead to cherry-picking in how providers showcase their results? Additionally, will the overall measure be risk-adjusted for social demographic or social risk factors? If they are, they may obscure true differences in quality and potentially obviate progress towards greater disparities reporting. In contrast, stratification -- which compares quality between the groups to show how similar or different they are -- is a simple concept for providers, patients, and families to understand and can be very helpful in patient and family decision-making.

Finally, as CMS considers measures for disparities reporting, AARP supports prioritizing measures with identified disparities in treatment or outcomes, or conditions that have highly disproportionate prevalence in certain populations. In addition, we support prioritizing outcome measures and measures of access and appropriateness of care.

Hospital Inpatient Quality Reporting Program

Endorsement of Selected New Measures: AARP supports CMS’ focus on health equity generally and its proposed three measures specifically. The National Academies of Science, Engineering, and Medicine identified “commitment to health equity” as one of six health care system practices that “show promise for improving care for socially at-risk populations.” Given the supporting literature, coupled with the NQF’s Measure Applications Partnership Advisory Group’s December 2021 vote on suitability of Hospital Commitment to Health Equity measure for the Hospital IQR program, AARP supports its inclusion. Likewise, AARP supports the voluntary Screening for Social Drivers of Health and the Screen Positive Rate for Social Drivers of Health.

In addition, AARP is concerned about opioid-related adverse drug events during and immediately after inpatient hospital stays. This phenomenon is associated with increased costs, lengths of stay, readmissions, and mortality, and is more common among older adults. To track and improve quality for all, particularly older adult patients, it is appropriate for hospitals to be held accountable for adverse drug events among inpatient adults involving opioid followed by opioid antagonist use (naloxone) within a 12-hour period.

Another concern to AARP is the well-documented underdiagnosis of malnutrition among older hospitalized adults. The literature includes extensive documentation of the association between malnutrition and negative clinical outcomes, including increased mortality and prolonged hospital stays. However, hospital-based malnutrition quality improvement efforts have yielded meaningful reductions in, for example, 30-day readmissions. AARP applauds CMS’s efforts to recognize hospitals that screen, diagnose, and develop a nutrition care plan for affected adults aged 65 years and older.
Support for two new National Healthcare Safety Network (NHSN) measures: AARP is pleased that CMS is considering measures for inclusion into the NHSN around two healthcare-associated conditions that are devastating to older Americans: *Clostridiodes difficile* (*C. diff*) and hospital-onset bacteremia and fungemia (HOB) outcome.¹¹ Both are widely accepted to be preventable conditions; indeed, a majority of surveyed hospital epidemiologists assert that HOB is preventable, that its presence reflects a hospital’s quality of care, and explicitly favor public reporting on HOB.¹²,¹³ Given the recent—and anticipated resurging—spikes in hospital census during the ongoing COVID-19 pandemic, policy aimed at preventing already overtaxed hospital resources from having to remediate healthcare-associated infections has never been more critical.

Conclusion

AARP thanks you for the opportunity to comment on the proposed regulations, and for your continued work to combat health care disparities. We look forward to working with you to ensure equitable access, quality, and outcomes for all older Americans. If you have any questions, please feel free to contact me or reach out to Andrew Scholnick of our Government Affairs team at ascholnick@aarp.org or 202-434-3793.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs