



June 9, 2023

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

Re: CMS-1785-P Fiscal Year 2024 Medicare Hospital Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System Proposed Rule

Dear Administrator Brooks-LaSure:

AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the opportunity to comment on this Medicare Hospital Inpatient Prospective Payment System proposed rule for FY24. We applaud the Centers for Medicare & Medicaid Services' commitment to health equity and access for the more than 65 million Medicare beneficiaries. Our comments focus on measuring health care quality disparities, proposed changes to the data collection and reporting requirements for hospitals, and support for family caregivers.

Health Equity Adjustment in HVBP

CMS proposes a health equity adjustment (HEA) in the Hospital Value-Based Purchasing (HVBP) Program beginning with the FY 2026 program year. The HEA would be calculated using a methodology that incorporates a hospital's performance across all four domains for the program year and its proportion of patients with dual eligibility status (DES). Hospitals that serve a higher proportion of DES patients and that perform well on quality measures would receive a larger payment adjustment.

AARP supports that the approach proposed takes into account performance as well as the extent to which a facility serves underserved populations. AARP firmly believes that ensuring health care equity promotes better quality care for all older Americans and recognizes the need to ensure resources are provided to facilities in a manner that allows for improved quality of care for underserved populations.

CMS requests comment on the use of DES to measure the proportion of residents who are underserved. AARP recognizes that DES data, at present, is available and familiar within the hospital setting, and may be an appropriate measure for now. However, DES does not reflect many other social risk factors that have equal or even greater effect on patient outcomes. Nor does it reflect bias and discrimination that some populations may encounter which affect access,

care, and outcomes. Therefore, we agree that future consideration should also be given to other measurements.

Request of Information on Potential Additional Changes to Address Health Equity

In addition to its HEA proposal, CMS requests comment on other ways to incentivize the achievement of health equity in the HVBP Program by identifying and incorporating populations that have been disadvantaged, marginalized, and/or underserved by the healthcare system.

AARP commends CMS for its sustained commitment to exploring issues of health equity and care disparities in the HVBP program specifically, and across its quality program portfolio generally. We agree the HVBP program should incorporate and reward the consistent delivery of high-quality care to all Medicare beneficiaries regardless of their demographic and social risk factors. We remain committed to working with CMS and other stakeholders to ensure all our nation's seniors who seek hospital care can achieve optimal and equitable health outcomes.

CMS specifically seeks comment on demographic variables and social risk indicators that would be most appropriate for assessing disparities and measuring improvements in health equity in the HVBP Program. AARP recommends that potential variables be required to have clear, standardized definitions and be meaningful to individuals and their family caregivers, as determined through a formal and transparent process for obtaining their input. Variables chosen for investigation should also have robust and established data sources. AARP recognizes the strong value of patient-reported data, but also acknowledges there may be limited availability of such data in the current quality program portfolio. Therefore, we encourage CMS to consider capturing variables and indicators among Medicare and Medicaid beneficiaries, which have been documented to correlate with care disparities, but for which there is limited person-level data currently available across CMS reporting systems. We also recommend reviewing the set of principles AARP developed for race and ethnicity metrics based upon our experiences with stratified tracking of state-level COVID-19 data.¹

CMS has elsewhere sought comment on specific approaches, such as stratification and risk adjustment, that may be applied in conjunction with potential incentive approaches to advance health equity. In general, AARP believes stratification is a necessary step to both highlight disparities and develop action steps. AARP supports CMS' use of within-provider and across-provider stratification because both provide important information for health care providers, patients, and their families. The former highlights disparities in individual 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 is critical for consumer and family caregiver engagement and informed decision making. We emphasize, however, that reliable stratified results demand consistent collection of standardized data elements, principles for which we have articulated to you in [prior comment letters](#).

¹ Carter B and Hado E. Using Data to Disrupt Health Disparities: Lessons Learned from the Coronavirus Pandemic. AARP Blog. November 9, 2020. Available at <https://blog.aarp.org/thinking-policy/using-data-to-disrupt-health-disparities-lessons-learned-from-the-coronavirus-pandemic>.

In addition, AARP continues to believe that transparency is a significant driver of improvement, is effective at changing behavior, and is essential in assisting individuals and their family caregivers in their informed decision making. To that end, making meaningful progress in reducing disparities should include public reporting of stratified measures. However, we encourage CMS to consider potential unintended negative consequences of reporting stratified measures alongside an overall measure. For instance, if both stratified measures and overall measures are both reported, it is important to present them in a meaningful and transparent way such that having two sets of measures does not create confusion among individuals and caregivers or lead to cherry-picking in how providers showcase their results. In this case, if the overall measure is to be risk-adjusted for social demographic or social risk factors, that 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, individuals, and families to understand and can be very helpful in consumer and family decision-making.

Lastly, we encourage CMS to measure successful performance within a domain by documenting the actions and efforts of the provider, rather than the provider merely attesting to completion of elements of such measures within the domain, and by auditing documentation of element completion rather than relying solely on attestation. To provide more actionable information for consumers, CMS may also want to consider keeping different measures within a domain as separate scores and not just a composite score for the domain.

Up-to-Date COVID-19 Vaccination Among Healthcare Personnel

AARP strongly supports the proposed modifications to the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 vaccine) measure in both the inpatient and the long-term care hospital settings. We agree that the definition of completed vaccination used in the HCP COVID-19 measure should be changed to “up to date” instead of the current “complete vaccination course”. The appropriate level of vaccination is an evolving standard as vaccines change in response to new variants. A “complete vaccination course” suggests a finite end, whereas “up to date” allows for the possibility of boosters. Throughout the pandemic, older Americans have been disproportionately impacted by high rates of morbidity and mortality from COVID-19. Recognizing the expiration of the public health emergency declaration on May 11, 2023, AARP continues to believe that adherence to infection prevention and control measures is essential to the health, safety, and well-being of hospital staff and the Medicare beneficiaries they serve. COVID-19 vaccinations and boosters have been effective tools in helping prevent the severe consequences of COVID-19, including high hospitalization rates.

Potential Future Inclusion of Two Geriatric Care Measures and Potential Establishment of a Related Publicly Reported Hospital Designation

CMS seeks public feedback on the potential future inclusion of two geriatric care measures for the Hospital Inpatient Quality Reporting program. Specifically, the proposed measures assess hospital commitment to improving inpatient outcomes in general (MUC2022-112), and surgical

outcomes in particular (MUC2022-032), for patients 65 years of age and older. AARP strongly supports CMS measuring person-centered care and holding hospitals accountable for achieving quality of care and safety for all older patients. We urge you to adopt these measures in the IQR program as quickly as possible, and to continue developing other measures that reflect the unique health needs of older Americans.

CMS is also considering a geriatric care hospital designation to be publicly reported on a CMS website, which could initially be based on data from hospitals reporting on both Geriatric Hospital and Geriatric Surgical structural measures considered above, if such measures were to be proposed and finalized in the future. CMS seeks feedback on the potential future designation and additional measures to consider for incorporation in the designation for future years, and on specific questions including:

How should the potential future hospital designation for geriatric care capture the role of family caregivers in hospital care delivery, care transitions, or discharge planning?

AARP appreciates CMS asking this question about capturing the role of family caregivers, since they are the backbone of our nation's health care and broken long-term care system. Family caregivers often assist older adults with activities of daily living (eating, bathing dressing, etc.), instrumental activities of daily living (grocery shopping, meal preparation, household chores, etc.), and medical/nursing tasks, as well as coordinating care among multiple providers and settings and advocating on behalf of their loved one. Caregivers are often particularly important in care transitions. To capture the role of family caregivers, AARP suggests that if the hospital is in a state with the CARE Act as law, the designation should consider the hospital's implementation of the CARE Act. In general, the designation should consider whether the hospital identifies family caregivers (including in medical records), includes them as part of care teams for patients and shares information with them with the consent of the patient and family caregiver (voluntary for family caregiver), and provides appropriate support, training, or referrals to family caregivers for information, assistance, and resources in the community. Family caregivers can have a significant impact on outcomes and quality of care for older adults.

Adoption of Computed Tomography (CT) Quality Measure

AARP supports the adoption of the CT quality measure "Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults" into the Inpatient Quality Reporting Program. Furthermore, we recommend its inclusion be implement in 2024 – one year earlier than proposed – for an initial year of voluntary reporting. While CT provides numerous benefits to patients and clinicians, currently there is wide variation in the radiation doses used for CT and no oversight or guidance on what is appropriate, excessive, or could cause harm to patients. Patients can get a dose 10x higher at one hospital versus another for the same type of exam, and many are uninformed about the risk of radiation exposure from CT. This variation is unacceptable and constitutes a profound quality issue. Further, the evidence

suggests that the doses can be reduced without impacting their diagnostic value. Lower doses could reduce harm, such as cancer risk. The Excessive Radiation measure would provide a standardized method for monitoring the performance of diagnostic CT.

Inclusion of Family Caregivers in Quality Reporting

In several instances throughout these proposed rules, CMS specifically mentions caregivers or family caregivers when proposing changes and soliciting feedback on quality reporting metrics. AARP applauds CMS's action to better recognize, assist, include, support, and engage our nation's family caregivers.

Throughout Medicare quality reporting programs, AARP believes there is an existing measurement gap related to support for family caregivers, including caregiver status. AARP strongly recommends the addition of Caregiver Status to the list of standardized patient assessment data elements required for reporting regardless of setting. This data point would identify whether the beneficiary has a family caregiver (who may or may not be the next of kin) and identify that individual to the provider or facility, including contact information (with consent of the individual and the family caregiver). Furthermore, involving the caregiver during the discharge planning process can help the beneficiary make a smooth transition home or to the next provider setting. Absence of an identifiable caregiver also may serve as a marker for other social risk factors that influence individual outcomes (e.g., social isolation) and could be a valuable element for use in stratified performance reports for facilities. It also provides an opportunity to identify and provide needed support for a family caregiver, such as education and training, especially around care transitions.

To this end, family caregivers should be identified in electronic records (as well as paper records) of the person they are assisting so they can appropriately be part of their loved one's care team if a care or service plan depends on having a family caregiver. Family caregivers can impact the beneficiary's care, outcomes, and quality of life. Their identification facilitates engagement, communication, and coordination with the caregiver, as well as the provision of caregiver support, as appropriate. Including this information would be an important step for further development of quality measures related directly to family caregivers. We hope you will continue to seize the opportunity to advance policies that make it easier for family caregivers to find the information they need and help ensure caregivers are appropriately included in their loved one's care.

Other Provisions

CMS proposes changes to regulations related to physician self-referral law and physician-owned hospitals. In general, AARP supports the proposed reinstatement of program integrity restrictions on facility expansion and supports the revisions to the process for requesting an exception from the prohibition on expansion of facility capacity. These restrictions will help ensure facilities are

not consolidated and concentrated in specific areas. Rather, they will encourage wider breadth of access and choice among Medicare beneficiaries.

CMS further proposes that all providers and suppliers that enroll in Medicare disclose “private equity company” and “real estate investment trust” ownership information. AARP supports this disclosure of ownership information for hospitals and health care facilities. Unfortunately, too often the interests of owners do not fully align with the interests of patients. Data on ownership will help inform analysis of resource allocation, utilization, capital investment, and other factors that impact the quality of care delivered by health care facilities.

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,

A handwritten signature in black ink, appearing to read "David Certner", with a stylized flourish extending to the right.

David Certner
Legislative Counsel and Legislative Policy Director