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June 17, 2022

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1771-P
P.O. Box 8013
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure,

The Society of Hospital Medicine (SHM), representing the nation's hospitalists, is pleased to offer our comments on the proposed rule entitled: *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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation [CMS-1771-P]*.

Hospitalists are physicians whose professional focus is the general medical care of hospitalized patients. They are the are front-line healthcare providers in America's hospitals for millions of patients each year. As a result, hospitalists have been at the forefront of the COVID-19 pandemic, risking their health and safety to provide high-quality care to hospitalized patients in hospitals across the country. In addition to managing clinical care, hospitalists also work to enhance the performance of their hospitals and health systems. The unique position of hospitalists in the healthcare system affords a distinctive role in facilitating both the individual physician-level and systems- or hospital-level performance agendas.

Throughout the COVID-19 Public Health Emergency (PHE), the Centers for Medicare and Medicaid Services (CMS) issued numerous waivers and flexibilities to allow hospitalists and hospitalist groups to respond rapidly to the challenges of the PHE. As the expiration of the PHE draws nearer and hospital care begins to return to normalcy, SHM welcomes the agency's proposals that continue to weigh the impact of COVID-19 on existing programs and measures in the Medicare program.

SHM is pleased to provide comments on the following proposals:

Hospital Readmissions Reduction Program (HRRP): Proposed Updates and Changes

CMS has proposed to resume the use of the 30-Day Pneumonia Readmission Measure for the FY2024 program year in the Hospital Readmissions Reduction Program, which had been paused due to the impact of COVID-19 on the patient cohort associated with the measure. CMS concurrently proposed technical updates to measures in the HRRP to exclude patients with a primary or secondary diagnosis of COVID-19. We support this proposal and technical updates to adapt this pneumonia measure and the other measures in the HRRP to the reality that COVID-19 will most likely transition to endemic disease.

Hospital Value-Based Purchasing Program (HVBP): Proposed Updates and Changes

CMS proposed to suppress multiple measures in the HVPB for the FY 2023 performance year because of the COVID-19 pandemic's ongoing impact on performance measures. Measures proposed for suppression include HCAHPS, CAUTI Outcome Measure, CLABSI Outcome Measure, SSI Outcome Measure, *MRSA* Bacteremia Outcome Measure and *C. diff* Outcome Measure. As a result of widespread measure suppression under the HVPB, CMS has proposed not to provide a Total Performance Score in the FY23 program and will assign a neutral payment to all hospitals. However, CMS will continue to provide a feedback report to hospitals based on their performance in remaining measures. We continue to be supportive of proposals that account for the on-going effects of COVID-19 in hospitals and believe it is appropriate to suppress measures that have been disrupted by the pandemic.

We appreciate that CMS commented on the interplay between the HVBP program and the Merit-based Incentive Payment System (MIPS). The facility-based measurement option in the MIPS is a programmatic opportunity that allows facility-based physicians like hospitalists to receive a MIPS score based on their hospital's HVBP score. This option is applicable to all hospitalists participating in the MIPS. Because of the significant administrative effort involved in changing reporting methodology in the MIPS, we ask CMS to align the HVBP scoring and MIPS facility-based measurement scoring policies. We encourage CMS to promulgate a similar neutral payment adjustment policy for the MIPS facility-based measurement such that measure suppression in the Hospital VBP program does not inadvertently disadvantage hospitalists and other facility-based providers in the MIPS program.

Hospital-Acquired Conditions (HAC) Reduction Program: Proposed Updates and Changes

CMS has proposed to suppress the CMS PSI 90 measure and the five CDC National Healthcare Safety Network (NHSN) Hospital-Acquired Infection (HAI) measures from the calculation of measure scores and the Total HAC Score. As a result, CMS proposes not to penalize any hospital under the HAC Reduction Program FY2023 program year. Furthermore, CMS has proposed it will not calculate or report measure results for the PSI 90 measure in the HAC Reduction Program FY2023 program year. SHM supports these

proposals, as they are reflective of COVID-19's continued disruption to patient care and hospital operations.

Request for Information: Overarching Principles for Measuring Healthcare Disparities Across CMS Quality Programs

Throughout the United States, minority groups experience persistent health care inequities and disparities, including within the Medicare beneficiary population. CMS is committed to addressing and remedying health inequities. SHM lauds CMS for their commitment to achieving equitable healthcare outcomes. While we remain supportive of these efforts, it is extremely important that CMS provides ample opportunities to provide feedback on specific measures and approaches to measuring healthcare disparities *as they are developed* to maximize stakeholder input and buy-in while minimizing the risk of negative, unintended consequences.

Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Programs

CMS reviewed its current approaches to stratifying measure performance – "within-provider" and "across-provider." They state that each approach by itself is an incomplete picture of potential disparities in a provider's performance. We agree that packaging stratification results as a complementary set of data with the total measure results will provide more meaningful data.

Interpreting this data, particularly if there are multiple data points per measure per provider, may be a challenge. Therefore, we urge CMS to consider how to contextualize stratified data for ease of interpretation and recommend CMS develop support resources for providers as they examine their performance using new stratifications and analyses. We also caution the agency should be judicious in selecting which measures are stratified for disparities. Because reporting stratified data increases the volume of datapoints a group receives from CMS, data stratification should be targeted on the most high-value and impactful measures.

Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting Across CMS Quality Reporting Programs

As one of its proposed principles for selecting and prioritizing measures, CMS suggests prioritizing existing clinical measures. While we agree with many of the listed advantages to using pre-existing measures, we caution the agency to balance reducing the burden of developing purpose-fit measures with potential problems or limitations in many existing measures. We urge that adaptation of existing measures for disparity reporting must be reviewed and validated prior to implementation within CMS' reporting programs. For example, we have repeatedly commented on the appropriateness of the 30-day episode windows for readmissions measures. Research has indicated that thirty days is too long of a period to judge accurately whether a readmission is related to adverse hospital care or is a result of

external factors. Adding a disparity analysis onto the 30-Day Readmission measure would serve to assess data on an already flawed measure. CMS should be judicious in using existing measures to ensure the measure is meaningful as currently constructed and reported in addition to providing actionable information when disparity reporting methods are applied.

We also strongly support the points raised around sufficient sample size to enable reliable and representative comparisons. Because this data would be used by providers to address disparities in their practice, it is critical that disparity reporting be validated and that providers are receiving reliable information. As comparison pools become smaller, the risk of one or a few outliers affecting performance increases. That outlier could be indicative of care disparities or it could be the result of myriad confounding factors—with small sample sizes it may not be possible to identify root causes. We note that sample sizes may require data collection over a longer period than currently used for many of CMS' measures and may require retooling other program aspects in addition to the measures themselves.

Principles for Social Risk Factor and Demographic Data Selection and Use

We continue to be supportive of CMS identifying and utilizing resources that currently exist and track race and ethnicity data. Community-level data or area-based indices, like the American Community Survey or the Community Needs Index (CNI), already collect and aggregate demographic data. Rather than creating additional and excessive reporting burdens, CMS could use this already recorded information for its health disparities purposes. Using existing indices will ensure CMS and hospitals have access to information to address health outcomes disparities without creating new administrative and reporting burdens for hospitals and healthcare workers.

CMS also considers imputed sources (indirect estimates) of social risk information and patient demographics. We continue to be wary of using these methods, as they are susceptible to inaccuracies, particularly for multiracial and Indigenous persons. Stratifying measures using estimated social risk information or demographic may inadvertently exaggerate or disguise disparate outcomes. We caution CMS that although imputed estimation may be feasible, the assumptions and generalizations that underpin an algorithm raise concerns about the quality and validity of the data.

Furthermore, only accounting for race and ethnicity fails to capture the complete range of social factors that impact health, including language barriers, socioeconomic status, or zip code. Social determinants are important indicators of health, whereas analyzing inequities using race and ethnicity alone provide a less holistic portrayal of factors that impact health. If CMS moves forward with stratified measures, CMS must ensure that stratified measures do not inadvertently deepen inequities.

We are encouraged by CMS' efforts to address disparities and encourage CMS to be cautious when implementing expansions of its disparities methods. We also ask that CMS provide resources and support to help hospitals and providers interpret and understand any stratified data provided to them.

Identification of Meaningful Performance Differences

As CMS considers how to identify performance differences, we urge the agency to be mindful of how each of their methodologies may distort interpretation of the data. For example, the use of a threshold for performance creates an artificial cutoff where tiny differences in performance are either "acceptable" or "unacceptable." Benchmarking, on the other hand, may mask local or regional differences in patient populations and resource access and inadvertently penalize providers serving some of the most under-resourced and vulnerable communities across the country.

Guiding Principles for Reporting Disparity Results

Providing confidential reports of stratified measure results will help identify disparities and enable providers and healthcare systems to improve inequities. However, we are concerned the eventual public reporting of these measures will have the unintended consequence of discouraging more resourced patients from receiving care at hospitals with poor disparity scores, which may not necessarily be indicative of the quality of care the hospital provides. This could contribute to deepening resource inequity for patients who rely on safety net hospitals.

We are also concerned that disparity methods, while initially used for data collection and understanding, could be later used in punitive ways that worsen disparities. Hospitals that serve high percentages of under-resourced patients may have poorer scores, resulting in part from factors out of providers' control. Punitively withholding resources because of these scores will further disadvantage beneficiaries who cannot choose their hospital or healthcare system. Furthermore, the fear of penalties could discourage hospitals from providing care to under resourced patients. CMS must work to ensure reporting stratified measures does not inadvertently create more inequities for vulnerable patients or disincentives for access to care.

Hospital Inpatient Quality Reporting Program: Proposed Updates and Changes

CMS has proposed to add ten measures to the Hospital Inpatient Quality Reporting (IQR) Program, including screening measures for social determinants of health and an opioid-related adverse event measure. Our comments on the social drivers of health and opioid related adverse measures are below.

Screening for Social Drivers of Health and *Screen Positive Rate for Social Drivers of Health*

CMS has proposed to begin voluntary reporting of the Screening for Social Drivers of Health measure and the Screen Positive Rate for Social Drivers of Health measure beginning in 2023, with mandatory reporting beginning in 2024. If finalized, these measures would be the first patient-level measurements of social drivers of health in the Hospital IQR Program. CMS believes screening for social drivers of health would allow healthcare providers to identify and potentially help address Health-Related Social Needs (HRSN).

When these measures went through the Measures Under Consideration process, we noted we supported the concepts but have reservations about the implementation of these measures within pay for performance programs. We continue to caution against using these measures to penalize performance, particularly when the measure is structural (Screening for Social Drivers) or merely reporting rates of positivity (Screen Positive for Social Drivers), not clinical outcomes.

Hospital Harm Opioid Related Adverse Events

CMS has re-proposed the Hospital Harm Opioid-Related Adverse Events measure and proposes the adoption of this measure beginning with the CY 2024 reporting period. The intention behind this measure is for hospitals to track and improve their monitoring and response to patients who receive opioids during hospitalization. While we have been supportive of the concept and intention behind this measure, we expressed concerns regarding its ability to target hospital-administered opioids and therefore preventable events. The updated measure requires reporting when there is evidence of an adverse event within 12 hours of a hospital-administered opioid, which we believe better narrows the measure towards potentially preventable harms. We support this updated measure but encourage the agency to monitor the measure for unintended consequences, particularly if it seems to be over-sampling high risk patients who are at higher baseline risk of adverse events.

Conclusion:
SHM appreciates the opportunity to provide comments on the 2022 Inpatient Prospective Payment System proposed rule. If you have any questions or need more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Rachel Thompson, MD, MPH, SFHM
President, Society of Hospital Medicine