Society of Hospital Medicine
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June 24, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1716-P
P.O. Box 8013
Baltimore, MD 21244-1850

Dear Administrator Verma,

The Society of Hospital Medicine (SHM), on behalf of the nation's hospitalists, is pleased to offer comments on the proposed rule entitled: *Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2020 Rates (CMS-1716-P).*

Hospitalists are providers whose professional focus is the general medical care of hospitalized patients. Hospitalists are front-line healthcare providers in America's hospitals for millions of patients each year, many of whom are Medicare and Medicaid beneficiaries. They manage the inpatient clinical care of their patients, while working 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.

SHM shares CMS' vision for promoting high quality care, improving outcomes, and streamlining care coordination for Medicare beneficiaries, and the proposed rule was reviewed by SHM's Performance Measurement and Reporting Committee, a group consisting of practicing hospitalists and hospitalist leaders who are experts in measurement and assessment.

We offer the following comments on the proposals:

Proposed Changes to Diagnosis Code Severity Levels
CMS conducted a recent analysis of the severity level of diagnosis codes as part of an effort to update the MS-DRG payment system. Using this analysis, CMS is recommending changes in severity levels to nearly 1,500 diagnosis codes. The bulk of these changes, as indicated in the table below from the rule, are downgrading diagnoses classified as Major Complication or Comorbidity (MCC) to Complication or Comorbidity (CC) or CC to non-CC.

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PROPOSED MCC/CC SUBCLASS MODIFICATIONS						
Severity Level – CC Subclass	Version 36 Severity Level Number of Codes	Proposed Version 37 Severity Level Number of Codes	Percent Change	Proposed Version 37 Change to MCC subclass, Number of Codes	Proposed Version 37 Change to CC subclass, Number of Codes	Proposed Version 37 Change to Non-CC subclass, Number of Codes
MCC	3,244	3,099	-4.5%	N/A	136	17
CC	14,528	13,691	-5.8%	8	N/A	1,148
Non-CC	54,160	55,142	1.8%	0	183	N/A
Total	**71,932**	**71,932**	**N/A**	**8**	**319**	**1,166**

Given the magnitude of changes proposed, wide-ranging stakeholder impact, and risk of significant adverse financial impact for hospitalists and hospitals, the Society of Hospital Medicine recommends that CMS halt its proposed changes to the severity designations and institute a more transparent process for stakeholders to engage with CMS on these changes.

After reviewing a selection of the proposed changes, we believe CMS' approach relied too heavily on an algorithmic analysis of resource use that may not adequately capture the cognitive and clinical work associated with these secondary diagnoses. For example, reclassifying heart failure codes (I50.22, I50.32, I50.42) as "non-CC" does not reflect the complexity of managing care and treatment plans for patients with chronic heart failure and the other risks associated with these comorbidities. Neoplasms as secondary diagnoses, similarly, have significant impacts on care management and treatment plans, yet CMS is proposing to downgrade these codes from CC to non-CC.

As a second example, patients with end stage renal disease (ESRD) face significant risks of morbidity, mortality, increased length of stays, ICU admissions, and higher hospital costs. Despite these risks and the work associated with trying to mitigate these outcomes, CMS is proposing to change ESRD (N18.6) from an MCC to a CC. These examples raise significant concerns over the methodology and transparency of the entirety of CMS' review process and warrant not finalizing these proposed changes.

Another example broadly demonstrating the flawed methodology in adjusting these severity levels is "localized skin eruption due to drugs and meds taken internally" is getting upgraded from non-CC to a CC while many cancer diagnoses are being downgraded. As a result, a patient with pneumonia and lung cancer will seem have a lower DRG than a patient with pneumonia and a skin rash. With a flaw of this magnitude, the entire methodology for determining these changes needs to be questioned and reevaluated.

SHM has long advocated that cognitive care is undervalued in the current Medicare payment systems. We believe the analysis underpinning CMS' proposed changes will continue this trend of undervaluing services in what are already tight hospital budgets. A more transparent process would enable stakeholders to understand the inputs in CMS' analysis and contribute feedback on whether CMS is using appropriate valuations for each suggested change.

In the economic analysis of the rule, CMS notes that "Hospital categories that generally treat cases in the higher MS-DRG severity levels, such as large urban hospitals, would experience a decrease in their payments, while hospitals that generally treat fewer of these cases would experience a slight increase in their payments under the proposed relative weights." We caution that these extensive changes to severity level designations, the majority of which would be downgrades, no longer reflect appropriate

resource usage for patient care. If the revised designations understate resource consumption, the ensuing inadequate reimbursement could impact quality of care or even patient access to certain services over the long term. We also believe this proposal severely understates the potential impact of these changes on hospital finances, particularly within tertiary care and teaching hospitals. **We urge CMS to not finalize any of these proposed changes to related to diagnosis code severity levels and work with stakeholders to do a more deliberative review and, if necessary, updating of severity classifications.**

Inpatient Quality Reporting (IQR) Program: Proposed Policy Changes

Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e)

We share CMS' belief that the opioid epidemic is a crisis that must be addressed, and measurement in this area is welcome. This measure is designed to assess the proportion of patients concurrently prescribed two or more opioids and benzodiazepines, effectively discouraging providers from concurrently prescribing these drugs whenever possible. **We believe focusing this measure on new, rather than continued, opioid or benzodiazepine prescriptions given at discharge would be a more relevant and useful measure. We recommend CMS continue to work on this measure prior to implementation to ensure it is focused on the inpatient setting.**

Some patients enter the hospital as chronic users of opioids, and it would be difficult to stabilize their condition while also reducing and or eliminating their current opioid prescriptions, particularly for short-stay patients. Measuring new opioid prescriptions, on the other hand, will provide valuable data about hospital prescribing practices and may be a better indicator of hospital care. Considering that many concurrent prescriptions originate in outpatient settings, the measure as currently written could be more useful in other programs that encompass outpatient care, such as an Accountable Care Organization (ACO) and Bundled Payments for Care Improvement (BPCI) participants.

Hospital Harm — Opioid-Related Adverse Events eCQM

This measure assesses opioid-related adverse events in a hospital setting by measuring the administration of naloxone. It incentivizes hospitals to closely monitor patients who receive opioids, measuring the overall rate of harm within a hospital. **While we agree with CMS' intention to reduce preventable harms associated with opioid administration in the hospital, we recommend addressing our concerns below to refine the measure before implementing in the IQR.**

Measuring naloxone administration may help determine which hospitals have a high proportion of adverse opioid related events, but we are concerned this measure could unintentionally motivate providers to avoid the use of naloxone and the use of opioids even when such use is appropriate. Additionally, we are concerned that the measure has not been appropriately adjusted for high-risk groups, such as patients with sickle cell anemia, patients on comfort care or patients who are chronic opioid users. Excluding these groups will ensure the measurement to more accurately measure preventable opioid-related adverse events. We also recommend the measure require evidence of opioid administration for the duration of patient hospitalization, instead of only during the first twenty-four hours of admission, as this information will provide a clearer view of hospital-related and preventable adverse events. We disagree with the assertion in the proposed rule that only requiring documented opioid administration in the first 24 hours of hospitalization reduces complexity of the measure logic.

Proposed Adoption of Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data

This measure is designed to assess all unplanned readmissions that arise from acute clinical events requiring rehospitalization within 30 days of discharge. CMS is proposing to do a phased approach to adopting the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data. This hybrid measure would eventually replace the existing claims only Hospital-Wide Readmission measure.

While excessive rates of unexpected readmissions can demonstrate inadequate care, we are concerned that the structure of this measure will create significant administrative and financial burden. We agree that EHR data can provide more granular patient-level data, which has the potential to improve the specificity of measures. We disagree that existing EHR software can readily extract the data necessary to report for this measure. Existing software models will need significant updates, which will create a significant financial burden on hospitals. Additionally, we are concerned that the data collected in this measure is not directly related to readmission rate. We note, however, that the addition of EHR data elements does increase administrative burden for the measure, and it is unclear based on the rule whether the improvements in the measure outweigh the additional reporting costs.

We are also concerned that this proposed change does not address larger outstanding questions about the value and utility of the readmission measure and the 30-day window for readmissions. We strongly encourage CMS to engage with stakeholders about broader changes to readmissions measurement methodology in order to make the measure more meaningful and actionable for hospitals and providers.

Potential New Quality Measures: Hospital Harm—Pressure Injury eCQM

This measure, as designed, is meant to use electronic health record (EHR) data to assess a hospital's proportion of hospitalized patients who develop a new stage 2-4 pressure injury, deep tissue injury or unstageable pressure injury, or have a worsening of an existing injury to stages 2-4.

Existing measures, such as Patient Safety Indicator 03 Pressure Ulcer Rate, assess a facility's rate of pressure ulcers at stages 3-4. It remains unclear why this new HAPI measure incorporates stage 2 pressure injuries, which has the potential to greatly increase both a facility's rate of pressure injuries and the number of hospitals reporting the measure. The measure rationale and clinical recommendation statement do not clearly indicate a reason for this expansion.

Standardized data and staging assessments will be critical for the measure. We note that there can be some variability in how different clinicians may score a pressure injury and that this could have an impact on the reported rates of HAPI. CMS should strive, both with this measure and through other outreach efforts, to ensure clinicians are consistent in their reporting, to derive the most value and quality improvement from this measure.

Different environments within the hospital may also have different rates of pressure injuries. The measure may therefore be more meaningful for clinicians if there are performance benchmarks for these intra-hospital settings. For example, a hospital system with a high proportion of intensive care unit (ICU) beds may see a higher rate of HAPI when compared against a system with a lower proportion of ICU beds. Separate benchmarks based on setting or type of patients (e.g., observation, general inpatient

admits, post-operative, and ICU) could yield more actionable and meaningful feedback data. We encourage CMS to explore the effects of site stratification prior to implementing the measure.

We also encourage CMS to exclude patients receiving end of life care or hospice services from the measure, as the nature of their care is different from other patients. We do believe it would be possible to identify these patients through EHR extraction, particularly for patients admitted under hospice. It is important for the measure to be thoughtful about patients who transition to comfort care during their hospitalization. For example, a Do Not Resuscitate (DNR) order is viewed as a proxy for comfort care in some facilities, but in others this is considered separate from an order for comfort measures, a palliative care admission, or inpatient hospice/contract hospice admission. EHR abstraction will need to capture these differences across facilities.

Given that this harm area is already assessed by other claims-based and chart-abstracted measures, we strongly urge the CMS to avoid double counting events in quality assessment and pay-for-performance programs. We agree with the trajectory of moving towards EHR-supported measures where possible, but other measures assessing a similar cohort should simultaneously be removed.

Finally, CMS needs to consider the effects of case-mix on performance under this measure and to prioritize effective risk adjustment. Risk adjustment methodologies should ensure that hospitals that see sicker patients and are more likely to see a larger rate of pressure ulcers do not face penalties for the composition of their patient population.

Conclusion

SHM appreciates the opportunity to provide comments on the 2020 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,

Chris M Frost, MD

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President, Society of Hospital Medicine