

June 25, 2018

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-1694-P
P.O. Box 8011
Baltimore, MD 21244

Dear Administrator Verma,

The Society of Hospital Medicine (SHM) is pleased to offer the following 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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims (CMS-1694-P)*.

SHM represents the nation's nearly 61,000 hospitalists 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.

We offer the following comments on the proposals:

Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes

SHM agrees with CMS' proposed changes to the Hospital Value-Based Purchasing Program (HVBP) regarding removing duplicative measures in multiple inpatient reporting programs. We have consistently raised issue with measures being used to make assessments across different programs with performance-based payment adjustments. This double counts measures and exposes hospitals to

double jeopardy for their performance on a single measure. Duplicate measures can also lead to confusing feedback reports from CMS.

We do note that the HVBP forms a critical element of the facility-based reporting option for providers under the Merit-based Incentive Payment System (MIPS). We encourage CMS to keep this relationship in mind as future additions or removals of measures in the HVBP program are considered.

Proposed Revision of Hospital Inpatient Admission Orders Documentation Requirements under Medicare Part A

CMS is proposing to alter the requirements for hospital inpatient admission orders by removing language that states that a physician order must be present in the medical record and be supported by the physician admission and progress notes in order for the hospital to be paid for the inpatient services under Medicare Part A. **SHM is fully supportive of this revision and agrees that requiring a physician order coupled with the physician admission and progress notes is redundant.** We thank CMS for simplifying the process for admitting inpatients.

We ask CMS for guidance on how the proposal will interact with the other aspects of the inpatient admissions. In terms of the two-midnight rule, we have some concerns that these changes may further complicate admission decisions for observation patients who later require Skilled Nursing Facility (SNF) care. The proposal may make it more difficult to track time for purposes of the three-midnight rule which governs Medicare SNF coverage. For example, if a Medicare patient is in the hospital for three midnights and receives medically necessary care (which can include medically necessary care as outpatient observation), the hospital appropriately bills inpatient. However, exactly when that patient started to be an inpatient determines SNF coverage. We ask that CMS consider and provide guidance on the impact that removing the admit order requirement would have on time-based rules.

Inpatient Quality Reporting (IQR) Program: Proposed Policy Changes

We generally support the removal of measures proposed for future years based on the duplicative reporting, cost-to-benefit of reporting, and topped out measure factors. We believe streamlining and harmonizing the measures available for reporting in the IQR program is an important balance of reporting burden and benefit of reporting.

We appreciate the opportunity to comment on the proposed future inclusion of the hospital-wide mortality measures and the electronic clinical quality measure (eCQM) on opioid treatment.

Potential Inclusion of Hospital-Wide Mortality Measures: Claims-Only and Hybrid with EHR Data

CMS is considering whether to incorporate Hospital-Wide Mortality Measures (Claims-Only and Hybrid with Electronic Health Record (EHR) Data) in future iterations of the Hospital IQR Program. We note that this coincides with CMS' proposals to remove condition-specific mortality measures from the IQR program. Measuring mortality, while an important indicator, has significant challenges. Recent retrospective research has shown that *preventable* mortality rates are small and that it may be difficult to explain variability in rates by hospital systems and processes. We encourage CMS to consider how to implement the measure in the context of this reality, including potentially adopting an improvement scoring approach.

CMS should consider how to include patients who are transferred from observation care and from emergency departments of other inpatient facilities. While not technically admitted from their transferring institution, these patients should also be considered for risk of mortality, and at some institutions, have been shown to have higher observed mortality than predicted by risk models.

The measure does not include patients with principle discharge diagnoses, which CMS has identified as affording hospitals limited ability to influence survival. These diagnoses include anoxic brain damage, persistent vegetative state, Cheyne-Stokes respiration, brain death, respiratory arrest and cardiac arrest without secondary diagnosis of acute myocardial infarction. While we appreciate the attempt to tailor the measure to certain conditions, we believe some of these exclusions will mask preventable hospital harms and should be reconsidered.

We are also concerned that the exclusions of patients, particularly around hospice care, may not reflect clinical and health system realities. There are many barriers to hospice care and we believe the two-day hospice enrollment window for exclusion does not account for these limitations. Some patients may have severe illnesses and be appropriate for hospice, but it can take more than two days to determine if they have a relevant diagnosis and prognosis, for them to accept a hospice referral or for them to be enrolled in a hospice program, and not all patients who may benefit from hospice care will elect to do so. CMS should also consider how to incorporate patients on comfort measures only into this exclusion from the measure. Hospice decisions are often complex and take into account many factors and many people, including a patient's family members. We are also concerned that the pressure placed to complete such a potentially sensitive process within two days could be counterproductive to good patient care. The exclusion for hospice care, as currently structured, does not reflect these realities and may end up inappropriately holding hospitals accountable for these cases. We urge CMS to consider widening this two-day hospice window for exclusion to better account for barriers to hospice care. We suggest a four-day window, at a minimum, may strike a better balance for the purposes of this measure.

Potential Inclusion of Hospital Harm- Opioid-Related Adverse Events eCQM

CMS is also considering whether to include a hospital harm electronic clinical quality measure (eCQM) measure around opioid-related adverse events in future years of the IQR and the Medicare and Medicaid Promoting Interoperability Programs (formerly the EHR Incentive Programs/Meaningful Use). We applaud changes that have been made to the measure and encourage CMS to address additional concerns with the measure. We share CMS' belief that addressing opioid adverse events is important and that a measure in this area is welcome. However, we do have an overarching concern that the measure, because it is focused around the administration of naloxone, may have the unintended consequence of impeding prompt and appropriate naloxone use.

We ask CMS for clarity on the numerator for this measure, in that it seems to count each unique patient who received naloxone regardless of the frequency of administrations. For example, one-time, one-dose patients would count the same as patients who required two doses on three separate occasions. We are concerned this could hide significant institutional problems.

We continue to urge CMS to require that naloxone administrations counted for the measure are preceded by documented hospital administration of an opioid in all cases, which will help to exclude patient-administered opioids during the hospitalization. We acknowledge CMS' argument that not requiring evidence for hospital administration of an opioid could reduce reporting burden, however we

believe evidence of hospital administration is an important indicator of hospital harms and would illuminate opportunities for systems and process improvement. We also suggest that the measure be maintained as voluntary, rather than mandatory, to more fully monitor and test its ability to achieve the intended goal with minimal unintended consequences.

Conclusion

SHM appreciates the opportunity to provide comments on the 2019 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,



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President, Society of Hospital Medicine

