Society of Hospital Medicine
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June 28, 2021

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1752-P
P.O. Box 8013
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure,

The Society of Hospital Medicine (SHM), representing the nation's hospitalists and the hospital medicine teams, 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 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program (CMS-1752-P).*

Hospitalists are physicians whose professional focus is the general medical care of hospitalized patients. Members of the hospital medicine team, which includes hospitalists, nurse practitioners, physician assistants and other clinical and non-clinical staff, 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 in hospitals around 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 duration of 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 rapidly respond to the challenges of the PHE. Hospitalists have welcomed these flexibilities, as it has enabled them to focus on patient care, rather than excessive administrative burdens or worries about financial solvency. We are pleased to see many of these flexibilities extended in this proposed rule.

SHM is pleased to provide comments on the following proposals:

Hospital Readmissions Reduction Program: Proposed Updates and Changes

Proposed Flexibility for Changes that Affect Quality Measures During a Performance Period in the Hospital Readmissions Reduction Program

CMS proposes a policy to enable them to suppress the use of quality measures in the Hospital Readmissions Reduction Program when they determine that the COVID-19 PHE have affected the measures and their calculations significantly. CMS would continue to collect and calculate the measure's rates for that program year but suppress those rates for payment adjustment.

CMS also developed Measure Suppression Factors to guide how and when measures should be suppressed, including:

1. Significant deviation in national performance on the measure during the PHE
2. Clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the PHE for COVID-19
3. Rapid or unprecedented changes in:
    - clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or
    - the generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin.
4. Significant national shortages or rapid or unprecedented changes in: (i) Healthcare personnel; (ii) medical supplies, equipment, or diagnostic tools or materials; or (iii) patient case volumes or facility-level case mix.

SHM supports this proposal to allow CMS to suppress measures in programs during the COVID-19 PHE. We also support the proposed Measure Suppression Factors. Care pathways and systems continue to be disrupted by the pandemic, with significant deviations in patient mix and co-morbidities make assessing performance on long-standing readmission measures difficult. This policy would enable the agency to react to unexpected results in the program and make consistent decisions across programs. We encourage CMS to continue to monitor the impact of COVID-19 on their programs and make further modifications as warranted.

SHM also supports CMS adopting a measure suppression policy for future PHEs, enabling the agency's programs to adapt to future emergencies more rapidly. We believe the measure suppression factors for the COVID-19 PHE may adequately address future PHEs but encourage the agency to consider if other factors are warranted and to adapt to the specific nature of future emergencies.

Proposal to Suppress the CMS 30-Day Pneumonia Readmission Measure (NQF #0506) for the FY2023 Program Year

SHM supports the suppression of the CMS 30-Day Pneumonia Readmission Measure for the FY 2023 program year. CMS showed a high proportion of patients with a diagnosis of COVID-19 in the pneumonia measure cohort and concluded that either including or excluding those patients from measure calculations may distort accurate assessment of the care provided. We agree with these concerns and support the measure's suppression for the FY 2023 Program Year.

Technical Measure Specification Update to Exclude COVID-19 Diagnosed Patients form All Other Condition/Procedure-Specific Readmission Measures Beginning with FY 2023

SHM supports these measure specification updates to ensure that the remaining readmission measures accurately assess performance for patients with those diagnoses or procedures.

Request for Public Comment on Possible Future Stratification of Results by Race and Ethnicity for Condition/Procedure-Specific Readmission Measures

In line with our general comments on the RFI for future stratification of results by race and ethnicity across hospital quality programs, SHM supports efforts to examine and address disparities but has concerns about using imputed race/ethnicity data. We encourage CMS' efforts to address health equity and encourage CMS to look at other existing valid and reliable information about sociodemographic status to use in their assessments and stratification. For more detailed comments, we refer you to the *Closing the Health Equity Gap in CMS Hospital Quality Programs: Request for Information* section of this letter.

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

Proposed Measure Suppression Policy for the Duration of the PHE

CMS proposes a policy to enable them to suppress the use of quality measures in the Hospital VBP when they determine that the COVID-19 PHE has affected the measures and their calculations significantly. CMS would continue to collect and calculate the measure's rates for that program year but suppress those rates for payment adjustment. CMS also developed Measure Suppression Factors to guide how and when measures should be suppressed.

SHM supports this proposal to allow CMS to suppress measures in programs during the COVID-19 PHE. We also support the proposed Measure Suppression Factors. Care pathways and systems continue to be disrupted by the pandemic and significant deviations in patient mix and co-morbidities make assessing performance on long-standing measures difficult. This policy would enable the agency to react to unexpected results in the program and make consistent decisions across programs. We encourage CMS to continue to monitor the impact of COVID-19 on their programs and make further modifications as warranted.

SHM also supports CMS adopting a measure suppression policy for future PHEs, enabling the agency's programs to adapt to future emergencies more rapidly. We believe the measure suppression factors for the COVID-19 PHE may adequately address future PHEs but encourage the agency to consider if other factors may be warranted and to adapt to the specific nature of future emergencies.

Proposal to Suppress the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure (NQF #0166) for the FY 2022 Hospital VBP Program Year

CMS proposes to suppress the HCAHPS scores in the FY 2020 Hospital VBP program year and, by extension, will not calculate a score for the Person and Family Engagement domain. SHM supports the proposal to suppress the HCAHPS score for FY 2022.

Proposal to Suppress the Medicare Spending Per Beneficiary (MSPB) Measure for the FY2022 Hospital VBP Program Year

SHM supports the proposal to suppress the MSPB measure for the FY 2022 Hospital VBP program year. As CMS' analysis indicated, the mean cost of a hospitalization for a patient with a COVID-19 diagnosis was 44 percent greater than hospitalization for a patient without a COVID-19 diagnosis, suggesting that a COVID-19 diagnosis has a significant impact across the entire MSPB episode and because of the uneven dispersal of COVID-19 across the country and throughout the year, performance will diverge greatly from prior cost trends.

Proposal to Suppress the Five Healthcare-Associated Infection (HAI) Safety Measures for the FY2022 Hospital VBP Program Year

CMS proposes to suppress the five HAI Safety Measures (CAUTI, CLABSI, Colon and Hysterectomy SSI, MRSA, and CDI) for the FY 2022 program year. SHM supports this proposal as an appropriate response to the impact of COVID-19 on HAIs and their care.

Proposal to Suppress the Hospital 30-Day All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT-30-PN) Measure (NQF #0468) for the FY 2023 Program Year

CMS proposes to suppress the MORT-30-PN measure because of the clinical proximity of the measure to the disease pathogen or health impacts of the COVID-19 PHE. We support the suppression of this measure from the program for FY 2023 and encourage CMS' efforts to continue examining alternatives for how to manage the impact of COVID-19 on this measure.

Proposed Removal of the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (NQF #0531) Beginning with the FY2023 Program Year

CMS proposes to remove CMS PSI 90 from the Hospital VBP program, starting in the FY 2023 program because it is also reported and assessed in the HAC Reduction Program. SHM has consistently advocated for eliminating duplicate measures across programs to ensure that institutions are not potentially being penalized twice for the same measure. As such, SHM supports this proposal.

Updates to the Specifications of Four Condition-Specific Mortality Measures and One Procedure-Specific Complication Measure Beginning with the FY2023 Program Year to Exclude Patients Diagnosed with COVID-19

CMS proposes to exclude patients with a primary or secondary diagnosis of COVID-19 from the measure denominators of the Hospital 30-Day, All-Cause, Risk-Standardized, Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization, Coronary Artery Bypass Graft (CABG) Surgery, Chronic Obstructive Pulmonary Disease (COPD) Hospitalization, Heart Failure Hospitalization, and Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measures. SHM supports these technical changes to the measures to ensure that patient populations in these measures are consistent with patient populations in prior year assessments and consistent within the three-year performance period for the measures.

Proposed Scoring Methodology for the FY 2022 Program Year Due to the PHE for COVID-19

CMS proposes to assign a net-neutral payment amount for all hospitals in the FY 2022 program year, because no hospital in the program would be awarded a Total Performance Score (TPS) in FY2022. This accounts for the impact of measures suppressed in the program due to the COVID-19 PHE. SHM supports this policy as continued flexibility during the COVID-19 pandemic.

We ask CMS to explore the impact of this proposed policy on the Merit-based Incentive Payment System (MIPS) facility-based measurement, which is applicable to all hospitalists participating in the MIPS. We encourage CMS to promulgate a similar net-neutral policy for the 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

Proposed Flexibility for Changes that Affect Quality Measures During a Performance or Measurement Period in the HAC Reduction Program

CMS proposes a policy to enable them to suppress the use of quality measures in the Hospital-Acquired Conditions (HAC) Reduction Program when they determine that the COVID-19 PHE has affected the measures and their calculations significantly. CMS would continue to collect and calculate the measure's rates for that program year but suppress those rates for payment adjustment. CMS also developed Measure Suppression Factors to guide how and when measures should be suppressed.

SHM supports this proposal to allow CMS to suppress measures in programs during the COVID-19 PHE. We also support the proposed Measure Suppression Factors. The pandemic continues to disrupt care pathways and systems and significant deviations in patient mix and co-morbidities make assessing performance on long-standing measures difficult. This policy would enable the agency to react to unexpected results in the program and make consistent decisions across programs. We encourage CMS to continue to monitor the impact of COVID-19 on their programs and make further modifications as warranted.

SHM also supports CMS adopting a measure suppression policy for future PHEs, enabling the agency's programs to adapt to future emergencies more rapidly on its programs. We believe the measure suppression factors for the COVID-19 PHE may adequately address future PHEs but encourage the agency to consider if other factors may be warranted and to adapt to the specific nature of future emergencies.

Proposal to Suppress Third and Fourth Quarter CY 2020 Data from the FY 2022 and FY 2023 HAC Reduction Program

SHM supports CMS' proposal to suppress data from the third and fourth quarters of CY 2020 as a response to the impact of the COVID-19 on the measures in the HAC Reduction program.

We also encourage CMS to examine data in the first and second quarter of CY 2021 in recognition of ongoing regional variations in COVID-19 hospitalization rates as hospitals around the country continue to respond to the COVID-19 pandemic.

Closing the Health Equity Gap in CMS Hospital Quality Programs: Request for Information

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 and SHM lauds CMS for their commitment to achieving equitable healthcare outcomes.

Future Stratification of Quality Measure Results by Race and Ethnicity

CMS' existing disparities methods use Medicare and Medicaid dual eligibility as a proxy of social risk and indicator of risk of poor health outcomes. Using dual eligibility, they used two methods ("Within-Hospital" and "Across-Hospital") to assess disparities within a hospital's patient population and between hospitals across the nation. These methods were applied to readmissions measures.

In an effort to provide a more holistic view of health care outcomes, CMS has proposed using indirect estimates of race and ethnicity to stratify quality measures. They propose expanding the disparity methods to include stratification of the condition/procedure-specific readmission measures. However, indirect estimates of race are likely to be inaccurate, particularly for multiracial and indigenous persons. Stratifying measures using estimates may inadvertently exaggerate or disguise disparate outcomes. We caution CMS that although the 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. Furthermore, if CMS moves forward with stratified measures, CMS must ensure that stratified measures are not used to 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 interpret and understand any stratified data provided to them.

Improving Demographic Data Collection

CMS seeks feedback on hospitals collecting information such as race, ethnicity, gender identity, and other demographic information at the time of admission. They propose collecting standardized demographic information so the data can be used to identify existing inequities. In theory and concept, we understand that demographic data can be used as a tool to highlight and combat inequities. In practice, however, hospitals face significant challenges collecting data related to race, ethnicity, sexuality, and gender.

Collecting demographics data can be challenging and resource intensive, with hospitals relying on both intake staff and digital resources. The existing healthcare software also poses challenges in collecting demographics data. For example, hospitals may struggle to accurately collect gender identity because the hospital records may be designed to collect binary gender information. This is just one example that demonstrates the struggles with collecting complex and nuanced demographic information with existing tools and software.

While we are supportive of identifying and studying metrics to reduce disparities, it is important that data collection does not create overly excessive reporting burdens. Marginalized patients may also have legitimate concerns that self-disclosing demographic information like sexuality, gender identity, or tribal affiliation will negatively impact their care. As a result, patients may decline to self-identify, creating further challenges when collecting demographics information at the time of admission. We raise this concern to note that even self-reported data may have its own biases and may not accurately capture the range of experiences or risks faced by a population.

We strongly encourage CMS to work to identify and utilize resources that currently exist and track race and ethnicity data. Many community-level indices, like the Community Needs Index (CNI), collect demographic data. Rather than creating additional and excessive reporting burdens, CMS may find this information is already collected and recorded. 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.

Potential Creation of a Hospital Equity Score to Synthesize Results Across Multiple Social Risks

CMS has solicited feedback on the creation and confidential reporting of a Hospital Equity Score; this score would synthesize results across multiple social risk factors and disparity measures. The creation of this score could be used to identify hospitals that serve high numbers of minority patients and need additional funding and resources. However, hospitals serving high populations of marginalized patients may have limited abilities to improve a low equity score, so it is critical CMS does not penalize these hospitals and withhold much needed resources, particularly in already under-resourced hospitals. If CMS does move forward with the creation of a Hospital Equity Score, CMS could consider focusing on improvements from an individual hospital's baseline scores, as opposed to comparisons between hospitals.

We are also concerned that if these a Hospital Equity Score becomes publicly reported in the future, there is a potential for certain hospitals that are already under-resourced to face further financial and resource constraints, contributing to an ever-worsening cycle. Hospitals who care for high numbers of marginalized patients could be labeled as "bad" or "undesirable" and be further deprived of resources to improve the quality, safety and efficiency of their care. Patients who lack the ability to choose hospitals could end up worse off, receiving care in increasingly under-resourced facilities.

In summary, while increased access to and the collection of demographics data can be used to quantify, identify, and hopefully rectify disparate health outcomes, CMS must work to ensure this data is not used to inadvertently replicate or reinforce existing inequities. CMS must not to minimize social determinants of health when addressing disparities in health outcomes. We are pleased to see CMS' continued efforts to combat the health equity gap and look forward to reviewing future and detailed proposals in this area.

Hospital Inpatient Quality Reporting (IQR) Program: Proposed Updates and Changes

Proposal to Adopt the COVID-19 Vaccination Coverage Among HCP Measure Beginning with Shortened Reporting Period from October 1, 2021, through December 31, 2021, Affecting the CY 2021 Reporting Period/FY 2023 Payment Determination and for Subsequent Years

Society of Hospital Medicine

SHM appreciates that CMS is looking at ways to address vaccination status among healthcare workers and believes this metric could help encourage vaccination. We note that there exists significant regional variation in vaccination rates and that this may have an impact on performance assessment under this measure.

SHM also encourages CMS to consider assessing rates of influenza and other vaccinations as a way to incentivize behaviors in healthcare providers. We note that although prior generations had significant rates of vaccination across the range of available childhood vaccines, vaccine hesitancy has increased, resulting in potential gaps in coverage for younger healthcare workers.

We also encourage CMS to consider how to measure and assess healthcare worker COVID-19 infections, and other ways to assess the health and safety of the healthcare workforce.

Proposal to Adopt Two Medication Related Adverse Event Electronic Clinical Quality Measures Beginning with the CY 2023 Reporting Period/FY 2025 Payment Determination

CMS proposes to adopt two eCQMs around severe hypoglycemia and hyperglycemia. SHM has concerns about the difficulty in measuring severe hyperglycemia and the overall complexity of the measure. We also believe the measure could inadvertently result in an increased incidence of hypoglycemia, which has an established higher mortality rate. We caution against using the hyperglycemia measure.

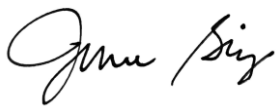
Potential Future Efforts to Address Health Equity in the Hospital IQR Program

CMS requests feedback on the potential development of a structural measure on hospital leadership engagement with health equity. SHM believes structural changes and investments in addressing healthcare disparities and health equity are critical. That said, structural measures can become compliance or "check-box" exercises. While we are supportive of the concept of the potential measure, we encourage CMS to consider how they might encourage high-quality and meaningful engagement with health equity.

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,



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