

June 9, 2023

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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1785-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure,

The Society of Hospital Medicine, representing the nation's more than 46,000 hospitalists is pleased to offer our comments on the proposed rule entitled *Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership (CMS-1785-P)*.

Hospitalists are physicians whose professional focus is the general medical care of hospitalized patients. They are the front-line healthcare providers in America's hospitals for millions of patients each year and were at the forefront of responding to the COVID-19 pandemic. 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.

SHM offers comments on the following proposals:

**Inpatient Quality Reporting Program**

CMS is proposing to add two measures to the Inpatient Quality Reporting (IQR) program relevant to hospital medicine: Hospital Harm- Pressure Injury eCQM and Hospital Harm- Acute Kidney Injury eCQM.

*Hospital Harm- Pressure Injury*

CMS proposes to add the Pressure Injury eCQM to the IQR program beginning with the CY 2025 Reporting Period/FY 2027 Payment Determination and

subsequent years. This measure is an outcome measure that assesses the proportion of inpatient hospitalizations for patients who develop new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury and is meant to incentivize the reduction of this harm.

SHM agrees avoidable pressure injuries should be targeted and prevented to the extent practicable. However, pressure injuries are already assessed as part of the PSI 90 composite measure in the HAC Reduction program. We continue to oppose CMS instating similar and/or overlapping measures across its programs.

In our experience with electronic health records (EHR) systems, different versions of the same EHR may have varying capabilities to report on measures. As CMS continues to move towards more eQMs, we ask the agency to test measures as broadly as possible to account for variations between EHR systems, as well as between different versions of the same EHR.

We also have concerns about several aspects of the measure specifications. First, this measure includes two different time courses in the numerator and denominator of the measure—stage 2, 3, or 4 or unstageable pressure injury greater than 24 hours after the start of the encounter and DTPI greater than 72 hours after the start of the encounter. The complexity will make it difficult to accurately collect time across settings in the hospital. We encourage CMS to simplify the measure by using a single time. Second, patients may unfortunately have long hold times in the ER, where the usual inpatient protocols for skin care cannot reliably be implemented. This raises concerns with what constitutes the beginning of the patient encounter. We would recommend the encounter start when the patient is admitted into the hospital onto the acute unit. Third, we advocate for an exclusion or other specification for patients who are moved into hospice care or comfort measures while an inpatient. Traditional prevention strategies for pressure injuries may not align with the patient's hospice or end of life care goals and we believe it would be inappropriate for this patient population to be included in this measure.

We urge CMS to reconcile the overlap of measures between programs and address our issues above before finalizing the inclusion of this measure in the IQR program.

#### *Hospital Harm- Acute Kidney Injury*

CMS proposes to add the Acute Kidney Injury (AKI) eQm to the IQR program beginning with the CY 2025 Reporting Period/FY 2027 Payment Determination and subsequent years. The measure is an outcome measure assessing the proportion of inpatient hospitalizations who have an AKI (stage 2 or greater) that occurred during the encounter. The measure is meant to incentivize the reduction of this harm.

SHM is opposed to the adoption of this measure. It is overbroad in its definition and does not target avoidable AKI as a preventable hospital harm. We encourage CMS to conduct more research, piloting, and refinement of the measure prior to its implementation. By narrowing this measure, CMS may better

assess avoidable or preventable AKI and provide actionable information to hospitals and care teams. For example, there are non-AKI related reasons why dialysis may be initiated in the hospital, yet the measure incorporates any dialysis started after 48 hours. We believe there should be, at a minimum, exclusions for dialysis started for non-AKI reasons.

Reducing avoidable AKI is an important goal. However, existing measures and guidelines targeted specific sites in the hospital, such as the ICU or interoperative settings. There is a lack of standardized guidelines for preventing AKI on the general medicine wards, and AKI incidents may not be as preventable in the general medicine setting as other specific settings.

We note that kidney injury is also captured in the HAC Reduction Program PSI composite measure. Although the measures are different and collect data in separate ways, we reiterate our opposition to CMS installing duplicative measures across its programs as this creates instances of “double jeopardy” for the same patients or cases. There is also a new administrative burden from this measure because of the different data collection and reporting modalities.

### **Hospital Value-Based Purchasing Program**

CMS proposes to add the Severe Sepsis and Septic Shock: Management Bundle measure into the Hospital Value-Based Purchasing program. We opposed the recent re-endorsement of the measure at the National Quality Forum and opposed the measure during the Measures Under Consideration process.

SHM serves on an IDSA-SHEA-led taskforce with several professional societies including the American College of Emergency Physicians, the Infectious Diseases Society of America, the Society for Healthcare Epidemiology of America, the Pediatric Infectious Diseases Society, and the Society of Infectious Disease Pharmacists. This group submitted a consensus statement during the Measures Under Consideration process in December 2022/January 2023 opposing the recommendation for conditional support of SEP-1 as a pay-for-performance measure. To date, our concerns have not been allayed and **we strongly oppose adoption of the Severe Sepsis and Septic Shock: Management Bundle (SEP-1) in the Hospital VPB Program.**

While we share CMS’s goal of improving outcomes for patients with sepsis, SEP-1 has not been successful in achieving this goal. At least four rigorous studies including data from hundreds of US hospitals now document that **SEP-1 has increased broad-spectrum antibiotic use but has not lowered**

**sepsis mortality rates or improved other patient-centered outcomes.**<sup>1,2,3,4</sup> We need to develop and promote other strategies if we are to meet our shared goal of lowering sepsis mortality. Continued investment in SEP-1 is a poor use of hospital and CMS resources because it is not meeting this core goal. One possible reason for this is that SEP-1 focuses exclusively on the initial hours of care and lacks incentives to examine and optimize subsequent care. This is critical because patients with sepsis tend to be hospitalized for long periods and are at risk for multiple complications of hospital care (including nosocomial infections, pressure injuries, delirium, deconditioning, fluid overload, acute kidney injury, etc.). SEP-1's sole focus on the initial 6 hours oversimplifies the complexity of comprehensive sepsis care and provides no incentive to hospitals to detect and mitigate these other profound risks to patients.<sup>5</sup> **We recommend that CMS retire SEP-1 and instead shift to sepsis metrics that focus on patient outcomes.** We support CMS's current work to develop a sepsis 30-day mortality electronic clinical quality measure (eCQM). Shifting SEP-1 from pay-for-reporting to pay-for-performance undermines this effort and sends the wrong message to hospitals on how best to improve sepsis outcomes.

### **Hospital Acquired Conditions Reduction Program**

CMS requested feedback and comments from stakeholders on whether to include additional measures into the HAC Reduction Program in future rulemaking. Potential measures mentioned by CMS included opioid-related adverse events, severe hyperglycemia, severe hypoglycemia, pressure injury and acute kidney injury.

Broadly, SHM is opposed to incorporating measures in multiple programs, particularly where there are any financial risks. This includes when a measure is included in a pay-for-reporting and a pay-for-performance program. We recognize the financial incentives are different with those two program structures, but we do not agree on principle with overlapping or duplication of measures across programs, as it creates duplicative reporting, excessive burden, and redundant risk for the same measure. We suggest whenever CMS is proposing to adopt a measure into a second program, the measure should be proposed for removal from the first program.

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<sup>1</sup> Pakyz AL, Orndahl CM, Johns A, et al. Impact of the Centers for Medicare and Medicaid Services Sepsis Core Measure on Antibiotic Use. *Clin Infect Dis.* 2021; 72(4): 556-565.

<sup>2</sup> Rhee C, Yu T, Wang R, et al. Association Between Implementation of the Severe Sepsis and Septic Shock Early Management Bundle Performance Measure and Outcomes in Patients With Suspected Sepsis in US Hospitals. *JAMA Netw Open.* 2021;4(12):e2138596.

<sup>3</sup> Barbash IJ, Davis BS, Yabes JG, Seymour CW, Angus DC, Kahn JM. Treatment Patterns and Clinical Outcomes After the Introduction of the Medicare Sepsis Performance Measure (SEP-1). *Ann Intern Med.* 2021;174(7): 927-935.

<sup>4</sup> Anderson DJ, Moehring RW, Parish A, et al. The Impact of Centers for Medicare & Medicaid Services SEP-1 Core Measure Implementation on Antibacterial Utilization: A Retrospective Multicenter Longitudinal Cohort Study With Interrupted Time-Series Analysis. *Clin Infect Dis.* 2022; 75(3): 503-511.

<sup>5</sup> Klompas M, Rhee C, Singer M. The Importance of Shifting Sepsis Quality Measures From Processes to Outcomes. *JAMA.* 2023; 329(7): 535-536.

*Opioid-related Adverse Events*

We concur that avoiding hospital care-related opioid adverse events is a critical element in ensuring the safe use of opioids in healthcare. We continue to have concerns about this measure's ability to differentiate between events caused by hospital-administered opiates and patient self-administration, particularly in cases where both may be occurring simultaneously. We supported the updates to the measure last year that required reporting when there is evidence of an adverse event within 12 hours of a hospital-administered opioid. However, we continue to encourage CMS to monitor the measure for unintended consequences and other potential issues and adjust the measure accordingly prior to implementation in the HAC Reduction Program.

*Severe Hyperglycemia and Severe Hypoglycemia*

SHM agrees that targeting hyper- and hypo-glycemia are clinically important and could be valuable additions to the HAC Reduction program. We believe having these two measures complementary to each other balances the potential risks of each measure individually. In both measures, we encourage exclusions that would account for hospice and end-of-life care orders. We also encourage the agency to consider measures targeting more defined or meaningful events. We would recommend more specific parameters regarding hyperglycemia, as criteria which are too broad may potentially encourage inappropriate treatment, leading to the other avoidable measure - hypoglycemia. For example, a measure could assess events such as diabetic ketoacidosis (DKA), which would target a more specific and meaningful patient outcome for prevention.

*Conclusion*

SHM appreciates the opportunity to provide comments on the 2023 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](mailto:jboswell@hospitalmedicine.org) or 267-702-2632.

Sincerely,



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President, Society of Hospital Medicine