Society of Hospital Medicine
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June 10, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1808-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 and Medicaid Programs and the Children's Health Insurance Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes.*

Hospitalists are physicians whose professional focus is the general medical care of hospitalized patients. In addition to managing the clinical care of patients, hospitalists 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. It is from this perspective that we offer comments on the following proposals:

Inpatient Quality Reporting Program

CMS proposed several changes to measures included in the Inpatient Quality Reporting (IQR) Program, such as the proposed addition of an Age Friendly Hospital Measure and a Hospital Harms – Falls with Injury Measure. CMS also proposed changes to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

Proposal to Adopt the Age Friendly Hospital Measure
CMS has proposed the adoption of an Age Friendly Hospital measure to the Hospital IQR program. The U.S. population is aging rapidly, and one in five Americans is estimated to be over 65 years old within the next ten years. As our population ages, care becomes increasingly complex. Therefore, CMS has proposed the adoption of this measure in an effort to improve the quality of care delivered to our aging population.

The measure builds on age-friendly initiatives identified by a collaborative effort of multiple stakeholders, including the American College of Surgeons and the American College of Emergency Physicians. These stakeholders identified four

priorities (the "4 Ms"): What Matters, Medication, Mentation and Mobility. This measure creates a set of attestations to ensure hospitals are implementing initiatives that support the 4 Ms. To that end, the measure has five domains: Eliciting Patient Healthcare Goals, Responsible Medication Management, Frailty Screening and Intervention, Social Vulnerability, and Age Friendly Care Leadership.

SHM broadly supports the goals of this measure and other efforts to ensure hospitals are "age friendly." This goal is particularly salient given our population is rapidly aging. Patients in hospitals are increasingly complex, frail people who are elderly, a trend accelerated by the COVID-19 pandemic. We are supportive of this measure and encourage CMS to continue its efforts to develop programs and measures to ensure our healthcare system meets the needs of its patient population.

While the elements of this measure are important to improve care for the elderly in acute care settings, these elements are just as applicable, and sometimes more actionable, in outpatient settings. For example, conversations about care goals and advance care planning often take place during a hospitalization. However, it is preferable and less stressful for patients and families if such conversations had taken place prior to hospitalization. Early planning helps ensure patients and families are aligned on their goals long before a health crisis requires hospitalization. We strongly urge CMS to create age friendly initiatives that extend beyond acute care hospitals.

Proposal to Adopt the Hospital Harm – Falls with Injury eCQM
Patient falls are among the most commonly reported hospital harms and we agree the prevention of falls is an important priority. In an effort to reduce falls in the hospital, CMS has proposed to adopt the Hospital Harm – Falls with Injury electronic clinical quality measure (eCQM) into the Hospital Inpatient Quality Reporting (IQR) program. This measure would be the first eCQM on this harm in CMS' programs. It is more expansive in specifications than the fall-related component in the existing Patient Safety Indicator 90 (PSI-90) composite measure, which only captures fractures in the Medicare fee for service (FFS) beneficiary population. SHM supports the addition of this measure in the IQR program, a pay for reporting program that allows hospitals to elect reporting this measure. However, we caution CMS against moving this measure into pay for performance programs such as the Hospital Value-Based Purchasing Program.

This caution stems from the fact there is a limited evidence base for best practices on fall prevention within the hospital. Interventions without a strong evidence base may actually have unintended, and harmful, consequences for patients. For example, restricting mobility as a method of fall prevention can conflict with patient care goals because mobility limitations can contribute to muscle weakening in some patients. More research is needed to determine best practices to prevent falls while maximizing patient care goals and outcomes. We also believe this measure should have balancing/complementary measures focusing on patient goals of care and mobility to help monitor and counteract unintended consequences.

Proposal to Modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure
The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is a national, standardized instrument to assess patients' experiences and perspectives on their hospital care. CMS proposes to update the HCAHPS survey by adding new questions, modifying existing questions, and

removing several questions. New questions include topics around care coordination, restfulness of the hospital environment, and information about symptoms.

It is vital that patients have the opportunity to share their experiences in the hospital. It can provide valuable feedback that can be used to develop and strengthen a patient-centered system. However, SHM continues to have reservations about whether the HCAHPS is the appropriate tool to meet this goal.

SHM has broad concerns about the HCAHPS. The survey has low response rates, and there is limited evidence demonstrating the relationship between patient satisfaction, care quality, and clinical outcomes. Furthermore, many of the items within the survey are subject to extant factors such as staffing levels and availability of hospital resources. For example, certain services may need to be provided overnight due to shortages of staff or high patient volumes. While the care itself is needed, the overnight disruption would likely affect performance on questions within the survey. Performance on the HCAHPS may not actually measure the quality of staff themselves and instead capture wider, systems-level issues, such as widespread staffing shortages that are not within the control of individual clinicians. Structural context is important and should be considered as part of an evaluation of the HCAHPS tool.

Items in the HCAHPS have become priorities for the hospital, just like any other quality measure in a pay for performance paradigm. However, there are circumstances in which survey priorities are in direct conflict with patient care needs. For example, some patients may require more intensive monitoring and regular interventions (and, therefore, interruptions) overnight. While creating a restful environment is an important dimension of helping patients get better, restfulness cannot be prioritized to the detriment of patient needs and outcomes. We encourage CMS to engage stakeholders in a dialogue on how better to balance these competing priorities in its measurement programs.

The changes would also expand the number of items in the questionnaire from 29 to 32, although CMS estimates it would not significantly increase the time for patients to complete. However, the current HCAHPS survey already has low response rates. We believe increasing the survey length, even if the increase is small, will still negatively impact patient completion of the survey. After finishing a hospital stay and the significant amount of paperwork that accompanies it, patients simply do not want to complete more forms, including a long survey.

Request for Information (RFI) on Advancing Patient Safety and Outcomes Across Hospital Quality Programs

CMS requested information on how its programs could encourage hospitals to improve discharge processes and patient safety, particularly given limitations the agency sees in its existing programs and readmissions and excess days measures. We agree with CMS' assertions that the current readmission measures do not comprise the entirety of unplanned returns to the hospital.

CMS developed the Hospital Readmissions Reduction Program to reduce avoidable readmissions to the hospital. This program uses six claims-based measures to track unplanned inpatient readmissions within 30 days following discharge. The goals of this program are laudable, as readmissions increase costs and are an undesirable outcome for patients. However, evidence suggests the program is not working as

intended and hospitals have not been able to meaningfully impact readmissions. In addition, as CMS notes, the readmissions measures do not include observation care and emergency department visits after hospitalizations, limiting the value of data gleaned from the program. The HRRP is of limited utility as a quality metric if observation hospitalizations are excluded. Excluding outpatient (observation) hospitalizations in index and/or 30-day event counts will result in nearly 1 of 5 rehospitalizations becoming invisible under the HRRP.[1] Measuring rehospitalizations, which includes both admissions and observation stays, rather than just readmissions, will not provide for a more actionable quality measure, but it will create a more accurate and robust measurement of the extent of hospital readmissions.

SHM has long expressed concerns that the thirty-day time frame for readmission measures is too long to accurately assess care quality, both within the inpatient setting and at discharge. Numerous extraneous factors can impact hospital readmission within this period, including access to transportation, housing, food, and other social determinants of health. These factors are largely out of the control of the hospital and the inpatient clinicians. In a 2022 study assessing the HRRP, the researchers stated, "at best, the evidence…suggests that the HRRP has had no meaningful effect on the rate at which patients return to the hospital within 30 days of discharge. At worst, the HRRP has unfairly penalized hospitals caring for the most vulnerable populations in our country and potentially resulted in patient harm."[2] Another study suggests earlier readmissions (within 7 days of discharge) are more preventable by hospitals, whereas outpatient clinics and home were better for preventing later readmissions.[3]

We recommend shortening the readmission window to seven days. We believe a week is more reflective of the time frame in which the inpatient experience, rather than external factors, are the determining factor for hospital readmissions. A shorter time frame will help hospitals and clinicians better assess what they can do that impacts outcomes. CMS should also consider this shorter time frame for other similar measures in its programs.

CMS also discusses several condition specific (AMI, heart failure, and pneumonia) Excess Days in Acute Care measures that are in the Inpatient Quality Reporting (IQR) program. Several limitations are noted, including that the IQR is a pay for reporting program and the measures only cover certain primary discharge diagnoses. We have concerns that these excess days in acute care measures conflate observation, inpatient, and emergency department (ED) visits. While observation hospitalizations are similar to inpatient hospitalizations, both are distinct from emergency department visits. Therefore, we advise CMS that ED visits should not be treated the same as observation and inpatient hospitalizations in quality measures.

Proposed Transforming Episode Accountability Model (TEAM)

The CMS Innovation Center is proposing to test an alternative payment model as a mandatory bundled payment for five surgical episode categories: coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT) and spinal

[1] Sheehy A, Kaiksow F, Powell R, et al. The Hospital Readmissions Reduction Program and Observation Hospitalizations. J Hosp Med. 2021;16(7): 409-411.
[2] Figueroa J, Wadhera R. A decade of observing the Hospital Readmissions Reduction—time to retire an ineffective policy. JAMA Network Open. 2022; 5(11): e2242593.
[3] Graham KL, Auerbach AD, Schnipper JL, Flanders SA, Kim CS, Robinson EJ, et al. Preventability of early versus late hospital readmissions in a national cohort of general medicine patients. Ann Intern Med. 2018;168:766-74.

fusion. This model would be effective January 1, 2026 through December 31, 2030. The TEAM builds on the Innovation Center's learnings from prior models such as the Bundle Payments for Care Improvement (BPCI), BPCI Advanced, and Comprehensive Care for Joint Replacement (CJR).

Overall, SHM strongly cautions against instituting a mandatory model at a time when many hospitals are not only struggling financially, but also struggling just to maintain sufficient staffing levels to provide quality care. The upfront and ongoing investment these models require for success cannot be ignored, as it will be out of reach or unsustainable for many institutions. A voluntary model would allow CMS to proceed with testing and avoid putting institutions in further financial jeopardy, which ultimately places patient access to care at risk.

Hospital medicine groups were significant participants in the BPCI and BPCI Advanced models, affording experience with how bundled payment models operate and engage clinicians across the episode of care. Although the TEAM seems to be targeted at selected hospitals and specialists, we note that numerous clinicians, including hospitalists, will be involved in the team-based care of patients across these episodes. Hospitalists will very likely be involved in the care of many of these patients as the attending physician or as a consultant. Hospitalists typically manage other medical conditions, often serve as the first point of contact for nursing and other ancillary staff, and assist with discharge arrangements. Comanagement relationships between hospitalists and specialists are a hallmark of team-based care in the hospital and are critical to efficient, safe care for hospitalized patients. As such we recommend CMS establish mechanisms to ensure payment for the designated episodes is equitably distributed and supportive of the team-based care that makes hospitals work.

Conclusion

SHM appreciates the opportunity to provide comments on the 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,

Eric E. Howell, MD, MHM
CEO, Society of Hospital Medicine