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IDSA
Infectious Diseases Society of America

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: 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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Dear Administrator Brooks-LaSure,

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to comment on the fiscal year (FY) 2023 Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule. IDSA represents over 12,000 infectious diseases physicians, scientists and other public health and health care professionals specializing in the prevention, diagnosis and treatment of infectious diseases. Our members care for patients with a wide variety of serious infectious diseases, including COVID-19, antimicrobial-resistant infections, HIV, viral hepatitis and infections associated with cancer care, solid organ transplantation and injection drug use. Our members also lead hospital programs charged with antimicrobial stewardship, infection prevention and control, and emergency preparedness and response. We are pleased to support several components of the FY 2023 IPPS Proposed Rule as well as offer suggestions to strengthen some provisions, as detailed below.

Hospital-Acquired Condition (HAC) Reduction Program

CMS previously adopted a policy for the duration of the COVID-19 public health emergency (PHE) enabling it to suppress a number of measures from the Total HAC Score calculations for the HAC Reduction Program if it determines that circumstances caused by the COVID-19 PHE have affected these measures and the resulting Total HAC Scores significantly. Under this policy, CMS proposes to suppress all HAC Reduction Program measures, including the CMS PSI 90 measure and the five Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) health care-associated infection (HAI) measures (i.e., the CAUTI, CLABSI, MRSA, CDI, and Colon and Hysterectomy SSI measures), for the FY 2023 program year. If this proposal is finalized, CMS would not penalize any hospital under this program for the FY 2023 program year. **IDSA agrees with the continuation of this policy and strongly supports this proposal to suppress the aforementioned measures for the FY 2023 program year.** The COVID-19 pandemic negatively impacted staffing levels and supply chains, which in turn impact infection prevention

and control activities in hospitals. IDSA believes it would be inappropriate to penalize hospitals for matters beyond their control during the pandemic when hospitals have been overwhelmed.

In regards to the CMS PSI 90 measure, in particular, CMS proposes to not calculate measure results, to not provide the measure results to hospitals via their hospital-specific reports (HSRs), and to not publicly report those measure results on Care Compare. CMS would instead indicate "N/A" in confidential and public reporting for this measure. However, in regards to the CDC NHSN HAI measures, CMS states that it would use the previously finalized applicable periods to calculate measure results for the FY 2023 program year and that it would use those measure results in feedback reports to hospitals and as part of program activities, fulfilling its obligation under section 1886(p)(5) of the Act to provide confidential reports to applicable hospitals with information on their performance on measures with respect to hospital-acquired conditions. For the five CDC NHSN HAI measures, CMS would also report the measure results both via HSRs and public reporting methods. **IDSA agrees with these proposals that would continue providing information regarding hospital performance to hospitals and the public via the Care Compare tool and the Provider Data Catalog.** To further quality improvement and data visibility goals, it is important that CMS continues providing publicly available information on hospital performance and that hospitals continue to report CDC NHSN HAI measure data to CDC.

Medicare (Hospital) Promoting Interoperability Program

In this rule, CMS proposes to add a new Antimicrobial Use and Resistance (AUR) Surveillance measure to the Public Health and Clinical Data Exchange Objective of the Hospital Promoting Interoperability Program starting with 2023. The measure would give credit to eligible hospitals or critical access hospitals (CAHs) that attest to being in active engagement with the CDC NHSN to submit AUR data for the electronic health record (EHR) reporting period and to receive a report from NHSN indicating their successful submission of AUR data for the EHR reporting period. **IDSA is very supportive of CMS' proposal to require eligible hospitals to attest to satisfying the NHSN AUR Surveillance measure as part of the Hospital Promoting Interoperability Program.**

The NHSN AUR Module is a critical tool that allows facilities to report and analyze antimicrobial use and resistance data to inform benchmarking, identify and track resistant pathogens, reduce inappropriate antimicrobial use and resistance, and interrupt transmission of resistant pathogens at individual facilities or facility networks. While participation in NHSN's AUR surveillance is currently widespread, it remains voluntary, which results in incomplete participation, limits the generalizability of the data, and prevents all patients from receiving the full benefit of efforts to reduce inappropriate antibiotic use and resistance. Requiring the reporting of these data across hospitals would help to produce more comprehensive and real-time data on antibiotic use and resistance, which is essential to providing facilities, policymakers, and the public with a better understanding of the threat posed by antimicrobial misuse and resistance in the inpatient setting. Further, these data will support evaluation of current efforts to address antimicrobial resistance and inform targeted actions to ensure safe and appropriate care. The proposed policy is critical to help the U.S. achieve the goal set forth in the initial National Action Plan for Combating Antibiotic Resistant Bacteria of 95% of U.S. hospitals reporting these data to NHSN.

As CMS has cited, CDC has found that one-third to one-half of all antimicrobials used in inpatient and outpatient settings are either unnecessary or prescribed incorrectly, which facilitates the emergence of drug-resistant pathogens and exposes patients to needless risk for adverse events, such

as *Clostridioides difficile* infection. Antimicrobial-resistant infections seriously complicate and threaten our ability to perform procedures such as cancer chemotherapy, dialysis, cesarean sections, care of wounds and burns, joint replacements, transplants and other surgeries. Secondary resistant infections also complicate our responses to public health emergencies, including COVID-19. As such, efforts to prevent resistance and the spread of resistant infections are central to our preparedness and our ability to protect modern medicine.

This new policy should drive increased investment in NHSN from Congress and CDC to provide financial support and technical assistance to help facilities report data to NHSN, with a focus on small, rural and critical access facilities. Further, this policy should help prioritize use of hospital resources to support reporting and other efforts to combat antimicrobial resistance. Lack of resources should not be used as an excuse to delay implementation.

IDSA also supports efforts to ensure alignment across programs. We appreciate that this requirement would align with other NHSN reporting requirements (e.g., related to bloodstream infections and urinary tract infections) that are currently part of other CMS quality reporting and value-based payment programs, such as the Hospital Value-Based Purchasing (VBP) Program and the Hospital-Acquired Condition (HAC) Reduction Program.

IDSA has long promoted a multifaceted federal response to antimicrobial resistance that includes improved data collection and reporting, as well as antimicrobial stewardship, infection prevention, research and innovation. We thank CMS for identifying AUR reporting as a priority.

Future Considerations, Potential Future Inclusion of Two Digital NHSN Measures

CMS is seeking public comment on two digital NHSN measures, the NHSN Healthcare-Associated *Clostridioides difficile* Infection (CDI) Outcome Measure and the NHSN Hospital-Onset Bacteremia and Fungemia Outcome Measure, for future inclusion in the Hospital Inpatient Quality Reporting Program as well as other quality reporting programs, including the HAC Reduction Program, the Hospital VBP Program, the PCHQR Program and the LTCH QRP. These measures as the proposed measures have direct impact on hospital infection prevention and control (IPC) and antimicrobial stewardship (AS) programs, typically led by IDSA members.

For the NHSN Healthcare-Associated CDI Outcome Measure, **IDSA is generally supportive of future implementation of the measure in the various hospital quality reporting and accountability programs, but we would also like to share some concerns regarding administrative burden of reporting, potential gaming of the measure and considerations for improving measurement validity.** This rule states that CDC is planning to enable and promote reporting of the NHSN Healthcare-Associated CDI measure using Fast Healthcare Interoperability Resources (FHIR), but as FHIR capabilities within EHRs are evolving, reporting using Clinical Document Architecture (CDA) and other formats will be available for reporting. IDSA appreciates the Agency's and CDC's consideration for reducing the administrative burden of reporting this measure by leveraging technology. However, we remind CMS that electronic reporting is evolving. We have concerns that reporting this measure will prove to be burdensome to our members responsible for IPC and AS programs until FHIR and other electronic reporting capabilities have fully matured. **To mitigate additional reporting burden, we ask that CMS work with the CDC, Office of the National Coordinator for Health Information Technology (ONC) and EHR vendors to fully integrate electronic reporting options for this and other NHSN quality measures within EHRs before future implementation.**

In regard to potential gaming of the NHSN CDI measure, we are concerned that hospitals may discourage health care practitioners from testing patients for CDI in order to reduce the number of patients included in the numerator, or alternatively, encourage practitioners to empirically treat patients suspected to have CDI rather than diagnostically confirming CDI. These potential unintended consequences may lead to overuse of antimicrobials that contributes to antimicrobial resistance or patient safety issues associated with undertreatment of patients with CDI. **IDSA is supportive of CMS' phased and required approach to initially adopt this measure under the Inpatient Quality Reporting (IQR) — a pay-for-reporting program — prior to tying payment to performance, but we also recommend that CMS work with CDC to observe any practice patterns that may emerge related to gaming after the measure has been implemented.**

Finally, in regard to measurement validity, as treatment data will now also be used to calculate the number of observed patients with CDI in the numerator, we have concerns regarding the antimicrobial agent metronidazole. Metronidazole is used to treat patients with CDI, as well as many other infections, and in combination with laboratory data, a patient on metronidazole may be falsely attributed to the numerator. Additionally, in calculating expected number of hospital-acquired CDIs, hospital characteristics such as whether a hospital is an academic referral center or a community hospital may impact performance scores. **IDSA suggests CMS work with CDC to review measure-testing data to evaluate whether risk adjustment based on hospital characteristics is needed to have valid, comparable hospital performance scores and if patients being treated with metronidazole account for significant falsely attributed CDI cases.**

For the NHSN Hospital-Onset Bacteremia and Fungemia (HOB) Outcome Measure, IDSA would like to share our concerns on the unintended consequences of the measure, the need for appropriate risk adjustment and exclusions to improve the measure. We have concerns that the broad focus of the measure on all bloodstream infections will prove extremely burdensome to infection preventionists (IPs) in the clinical setting. For example, if a hospital's HOB measure rates increase, an IP will have to review clinical data related to all patients with bacteremia and fungemia to identify the source(s) of the problem to plan improvement activities to decrease the HOB measure score. Another potential unintended consequence may be health care practitioners continuing inappropriate antimicrobial therapies for patients to exclude them from this measure. A more focused measure on specific types of bacteremia and fungemia would provide more pertinent, actionable data to health care practitioners to improve patient outcomes. Furthermore, the rule did not state that the HOB measure would be risk adjusted. To fairly compare hospitals, risk adjustment accounting for hospital acuity is needed. For example, a hospital that is a referral center and performs many surgeries may potentially have more high-acuity patients who are more likely to have HOB or fungemia. For exclusions, it would be clinically important to exclude positive blood cultures that are believed to be contaminants. **IDSA recommends that CMS work with CDC to address our concerns to create an improved measure that will equip practitioners with specific data to improve patient outcomes.**

Proposed Revision to Conditions of Participation (CoP) for Hospitals and CAHs to Report Data Elements for COVID-19, Seasonal Influenza, and Future Pandemics and Epidemics as Determined by the Secretary

IDSA agrees with the proposed continuation of the requirement for hospitals and CAHs to maintain COVID-19 and seasonal influenza reporting and electronic reporting of information on acute respiratory illness beyond the current public health emergency.

During the COVID-19 pandemic, hospital reporting of COVID-19 cases has dramatically increased, allowing greater access to accurate data. Timely access to data provides hospitals with the ability to do surge planning and adjust staffing and other resources based on expected patient volume. Local and state public health departments also need access to timely data to identify outbreak trends and determine appropriate prevention and mitigation measures to keep communities safe. More granular data is important to illustrate how an outbreak impacts subgroups, including disproportionate impacts based upon race, ethnicity, age, geography, gender and socioeconomic status. It is crucial to uncover disparities early and track them closely to inform equitable responses and target resources (such as limited quantities of therapeutics) to communities with the greatest need.

IDSA also agrees with the requirement for hospitals to report data in future public health emergencies to the CDC's NHSN, or other appropriate CDC-supported surveillance system, as determined by the Secretary. CDC has the scientific expertise and experience to guide the collection and analysis of this data. This approach also builds on existing systems within the federal government to avoid duplication of efforts. NHSN should be appropriately resourced to accommodate the influx of additional hospitals submitting data. Accordingly, small and/or rural hospitals should be provided with technical assistance and other resources to help them meet expanded requirements for data reporting. Without this assistance, a two-tiered system may result, with the most highly resourced hospitals providing data and benefiting from analysis of their patient population while small and rural hospitals do not have access to this analysis. IDSA stresses that resources should be prioritized for this effort and lack of resources should not be used as a reason to prevent or delay reporting.

IDSA thanks you for your attention to these important issues impacting our hospitals' approach to preventing, tracking and reporting on infectious diseases. We hope that our comments are useful as you work to finalize the FY 2023 IPPS rule. If you have any questions or if we may be of any assistance to you, please do not hesitate to contact Amanda Jezek, IDSA senior vice president for public policy and government relations, at ajezek@idsociety.org.

Sincerely,

Daniel P. McQuillen, MD, FIDSA, President
Infectious Diseases Society of America