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Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs

The Society of Hospital Medicine (SHM), representing the nation's 44,000[1] hospitalists, is pleased to offer comments on the Request for Information (RFI) entitled: *Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs*.

Hospitalists are physicians whose professional focus is the general medical care of hospitalized patients. They provide care to millions of Medicare beneficiaries each year and have served their communities heroically, caring for hospitalized patients on the frontlines of the deadly COVID-19 pandemic. It is from this perspective that we offer our comments on this RFI.

Accessing Healthcare and Related Challenges

Unsustainable Funding Model

The COVID-19 pandemic exacerbated and highlighted the inequitable and unsustainable funding model of our healthcare system. Without significant financial relief from Congress, our healthcare system would have collapsed from the financial strain of COVID-19. Relief efforts such as the Provider Relief Fund and increased telehealth reimbursement minimized the financial impact of the pandemic. However, the cancellation of elective surgeries and appointments significantly disrupted the financial stability of healthcare systems across the country. Throughout the past two and a half years, it has become increasingly clear that our healthcare system cannot financially sustain itself in crisis situations. Reimbursement rates for non-surgical life-saving care are insufficient to maintain normal financial operations. We must adequately and sustainably fund our healthcare system. If we do not make changes, we risk the catastrophic breakdown of the healthcare system during future pandemics and other crises.

Financial hardship in healthcare systems has never been distributed equally across the country and the pandemic intensified existing inequities. Some of the largest and wealthiest hospital systems have exited the acute phase of the pandemic relatively sound, buoyed by federal relief efforts. In many parts of the country, however, rural and smaller community hospitals emerged in precarious financial positions – if they have survived at all. The American Hospital Association reports a record number of 19 rural hospital closures in 2020.[2] Between closures and widespread financial instability, the healthcare safety net in our country is faltering. Patients in rural and underserved communities are disproportionately affected and are experiencing reduced access to quality medical care.

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[1] Lapps, J, Flansbaum, B, Leykum, LK, Bischoff, H, Howell, E. Growth trends of the adult hospitalist workforce between 2012 and 2019. J Hosp Med. 2022; 1- 5. doi:10.1002/jhm.12954

[2] Rural hospital Closures Threaten Access. American Hospital Association. September 2022. https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf?mkt_tok=ODUwLVRBQS01MTEAAAGG0JdMr3vWWxqvsOOfHHbsO2HYSTt0lBft456aaGd_8U4yOrJTu-THRk-RFyo-k-10HJh9JXC0TJGB6GYzjCol-hCq2Ow9QxvqeTqXMA5yqDxS

Opioid Use Disorder Treatment

The United States continues to struggle with two concurrent crises: the COVID-19 pandemic and the opioid epidemic. An important tool to combat the opioid crisis is Medication-Assisted Therapy (MAT) with buprenorphine. Prior to May 2021, clinicians were required to complete a specialized training to become "X-waivered" and prescribe buprenorphine. In May 2021, the Biden Administration made efforts to expand access to buprenorphine by issuing updated practice guidelines. Clinicians can receive an exemption from the training requirements and prescribe buprenorphine to up to 30 patients by submitting a Notification of Intent (NOI) to the Substance Abuse and Mental Health Services Administration (SAMHSA). However, clinicians must complete the X-waiver training to treat more than 30 patients concurrently.

Despite the relaxation of X-waiver training requirements, many patients continue to face significant barriers to treatment, including difficulty finding a clinician who is comfortable and willing to prescribe buprenorphine. SHM continues to believe the X-waiver is an outdated requirement that erects an unnecessary barrier to lifesaving addiction treatment. The X-waiver positions buprenorphine as a complicated, high-risk medication, despite evidence of its safety, efficacy, and low-rates of abuse. While this lifesaving medication is highly regulated, physicians are not required to seek out an additional special license to prescribe opioids for pain management, which are known to be addictive and have high potential for abuse. SHM continues to support the passage of the Mainstreaming Addiction Treatment Act (MAT) (currently included as part of the Restoring Hope for Mental Health and Well-Being Act of 2022 (H.R. 7666)) to eliminate the X-waiver, and we urge CMS to continue working within its jurisdiction to expand access to and reduce stigma associated with this lifesaving medication.

Workforce Shortages

According to the Association of American Medical Colleges (AAMC), the United States faces a physician shortage of up to 139,000 by 2033[3], an insufficiency exacerbated by the COVID-19 pandemic. We need policies that encourage the growth of the physician workforce, particularly in rural and underserved regions. Expanding the healthcare workforce to account for our aging population will acquire a multipronged approach, as a myriad of issues, like burnout, skilled immigration policies, and limited residency training spots contributes to the shrinking healthcare workforce. However, one way CMS can help with the workforce shortage is to remedy inadequate payment rates within the current Physician Fee Schedule. Payment rates for the delivery of non-surgical lifesaving care are unsustainable and not reflective of actual costs of care delivery. The finances of hospital systems and clinicians will be further strained by cuts to inpatient evaluation and management (E&M) services as finalized in the 2023 Physician Fee Schedule. Payment cuts will necessitate staffing cuts, further contributing to workforce shortages and increased patient census for the remaining clinicians. We have concerns that this will impact the quality of care for patients and lead to less coordinated care with duplication of services and other inefficiencies.

[3] HIS Markit Ltd. The complexities of physician supply and demand: projections from 2019 to 2034. Washington, DC: AAMC; 2021. https://www.aamc.org/media/54681/download?attachment.

Accessing Healthcare and Related Challenges Recommendations

Unsustainable Funding Model

CMS must work to establish an equitable payment system that ensures healthcare systems serving small, rural, and underserved populations have the resources they and their patients need. SHM, alongside the Infectious Diseases Society of America (IDSA), have consistently advocated for CMS to adopt new pandemic response policies, including an outbreak activation payment policy triggered by the emergence of a new infectious disease pandemic or epidemic. We believe an automatic payment policy would help avert the uncertainty and financial instability that arose from the dramatic shift in patient volumes the healthcare system experienced during the COVID-19 pandemic.

Opioid Use Disorder Treatment

Given the severity and extent of the opioid crisis, SHM urges CMS to prioritize using its full statutory authority to ensure patients with OUD can access treatment. We also encourage the agency to use its resources to develop and disseminate education for clinicians and patients aimed at destigmatizing and encouraging OUD treatment.

Workforce Shortages

While addressing the healthcare workforce shortage will require a multipronged approach, CMS must ensure reimbursement rates adequately cover the cost of care. Recently finalized updates to the PFS devalue inpatient care, and combined with other looming Medicare reimbursement cuts, may necessitate staffing reductions. We believe establishing a payment policy that properly reimburses inpatient services will help address workforce shortages within the hospital setting. Low payment rates for inpatient care have contributed to hospital staffing shortages, financial instability, and physician burnout. Continued cuts to these services will worsen an already inequitable system. Creating an equitable and sustainable mechanism to fund Medicare will help hospital systems recruit and retain high quality clinicians and medical staff.

Understanding Provider Experiences

Administrative Burden

Over the past two decades, hospitalists and other clinicians have encountered a marked increase of administrative burden in their workday. While maintaining adequate records and reporting quality data is important, excessive administrative tasks are a leading cause of burnout among physicians. Throughout the PHE, numerous quality reporting programs and other administrative burdens were made optional, helping clinicians manage a highly variable volume and acuity of patients. Hospitalists report the easing of administrative burdens significantly improved their workflows and workplace satisfaction. The PHE has provided an opportunity for CMS to re-evaluate reporting requirements and develop programs that encourage quality without excessive or duplicative reporting requirements.

Payment Cuts: Medicare Physician Reimbursement and Proposed E&M Rates

Hospitalists have been on the frontlines of the COVID-19 pandemic, providing high quality care to patients, despite personal health and safety risks. Despite heroic resolve, hospitalists are exhausted and face record-levels of burnout and staffing shortages.

Looming Pay-As-You-Go (PAYGO) and budget neutrality adjustments further demoralize the hospitalist workforce. Despite their constant, lifesaving work throughout the pandemic, clinicians face an approximate 8.4% payment cut in January. These cuts, coupled with rising inflation costs and the continuing financial impact of the PHE, will be disastrous, particularly for smaller and rural health systems. Every year, these payment cuts threaten the security and stability of the medical system. While Congress can avert these cuts, we urge CMS to develop policies to help sustainably fund Medicare reimbursements.

Hospitalists are exhausted and burnt out – and they are further discouraged by recently finalized updates to the Evaluation and Management (E/M) codes for inpatient services. Many of these updates, particularly for the three initial hospital visit codes (99221-99223), decrease payment for inpatient services. The payment reduction is not in line with the historical relativity of inpatient codes to comparable outpatient codes. These cuts do not reflect the value or cost of these care services and will negatively impact patient care. We urge CMS to fairly reimburse inpatient services by preserving relativity with the comparable office visit codes. Keeping E&M payment rates in line with the historical relativity of comparable outpatient codes will better demonstrate the value, cost, and complexity of inpatient care.

Understanding Provider Experiences Recommendations

Administrative Burden:
Given the exacerbation of burnout and subsequent workforce issues by the COVID-19 pandemic, CMS must prioritize reducing administrative burdens across its programs. We urge the agency to review its policies and programs for areas that can be streamlined or eliminated without negatively affecting patient care.

Payment Cuts:
We urge CMS to ensure hospitalists are appropriately compensated for the work they perform by ensuring of hospital-level E/M codes are not undervalued in the PFS and restoring their historical relativity to the office and outpatient visit codes.

Advancing Health Equity

Disparities in Access to Post-Discharge Care and Skilled Nursing Facility Placement
Nursing home closures precipitated by rising costs, COVID-related financial disruptions, and reduced reimbursement rates have created significant challenges to finding post-hospitalization SNF placement for Medicare beneficiaries. Many SNFs are already full, and despite the relaxation of prior authorization requirements and the three-day stay waiver, it is extremely difficult to find a SNF with beds available.

This challenge is heightened in underserved and rural communities. Hospitalists also report having more difficulty placing patients who are enrolled in Medicare Advantage (MA), as opposed to patients enrolled in traditional Medicare. SNFs are concerned MA plans will not adequately reimburse for the patient care provided. Limited network adequacy under MA plans also contributes to the difficulty in placing patients in SNFs.

The difficulty of finding SNF placement for select patient populations is a huge problem and is demonstrative of significant inequities within our healthcare system at large. Patient populations that face additional barriers to post-discharge placement in SNFs include bariatric patients, particularly those who are elderly, behavioral health patients, patients requiring dialysis, patients with a history of incarceration, patients that are underinsured, and patients on Medicaid. Hospitalists also often struggle to find SNF placement for cancer patients undergoing chemotherapy due to the high cost of medications. Patients with a history of substance use disorder (SUD) also face heightened barriers for post-acute placement, particularly if they require methadone treatment. The inability for patients to receive care at the appropriate clinical setting or level contributes to a shortage of acute care beds and unnecessarily prolonged hospital stays. CMS must develop policies ensuring patients have equitable access to SNFs and other post-acute care that supports patients' clinical needs.

Beyond the challenge of finding SNF placement for dialysis patients, many hospitalists, practicing in both rural and urban settings, report many of their dialysis patients are relegated to emergency-only dialysis. Dialysis patients may be declined from regular dialysis services due to missed or late appointments. We are concerned dialysis center performance metrics may have unintentionally created a situation where dialysis patients lack access to regular care because of transportation issues, delays, or missed appointments that are out of the patient's control. We are particularly concerned for patients in rural areas with limited access to, or options for, dialysis care. We urge CMS to review performance metrics for dialysis centers to ensure patients can get the care they need without significant barriers.

Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

Telehealth

Throughout the pandemic, CMS increased the number of services eligible for telehealth reimbursement. Telehealth expansion helped keep patients and providers safe through personal protective equipment (PPE) shortages and the pre-vaccination stage of the pandemic. While some of these services have been added to the Medicare Telehealth Eligible List on a temporary basis, others have been made permanently eligible for reimbursement. The rapid adoption and expansion of telehealth technologies will continue to create significant and lasting changes in the delivery of medical care.

Blanket waivers issued in March 2020 dramatically increased the use of and payment for telehealth, allowing clinicians to furnish telehealth services to patients anywhere in the country, including the patient's place of residence. This relaxed longstanding rules that limited Medicare telehealth coverage to very specific circumstances, ensuring beneficiaries maintained uninterrupted access to care, particularly in rural and underserved areas. Furthermore, increased payment rates for telehealth

services helped minimize the catastrophic financial impact of the PHE. While initially adopted as a safety measure, telehealth has become a critical and integral tool in medicine.

Skilled Nursing Facility Coverage: Three-Day Stay Waiver

Throughout the past decade, SHM has been involved in efforts to improve observation policies, ensuring beneficiaries receive quality care without exorbitant, unexpected out of pocket costs. Prior to the relaxation of the three-day stay requirement during the PHE, patients who required skilled nursing facility (SNF) care were required to be admitted into the hospital as an inpatient for three days to receive their SNF benefits. However, days spent in the hospital under observation do not count towards the three-day stay requirement, as this is considered outpatient care. Patients under observation are staying in a hospital and receive nearly identical care to those in inpatient care under Medicare Part A, although observation is billed as outpatient under Medicare Part B. As such, patients face highly variable out-of-pocket costs (coinsurance), particularly when they need post-acute care.

Because time spent under observation does not count towards the three-day inpatient stay requirement for Medicare skilled-nursing facility (SNF) coverage, patients are faced with the decision to pay extremely high and unexpected bills for SNF stays or forego necessary follow-up care. Functionally, these unexpected and costly medical expenses are surprise bills to patients. This policy negatively impacts the patient/physician relationship, may contribute to healthcare-related bankruptcy, and, because of financial uncertainties, often limits a SNF's willingness to accept a patient. Existing observation policies also serve to perpetuate existing healthcare disparities, as Medicare beneficiaries in the most disadvantaged communities are more likely to have an observation stay, have a repeated observation stay within 30-days, and experience long-term reobservation.[4]

In March 2020, CMS waived the three day inpatient stay requirement for Medicare Skilled Nursing Facility Coverage. The relaxation of the three-day stay requirement empowered clinicians to focus on the needs of patients, rather than outdated and overly burdensome administrative requirements. Despite challenges with placement due to COVID related bed capacity and quality of post-acute services, hospitalists reported this flexibility helped ensure that patients could receive the care they needed at the appropriate facility. The relaxation of the three-day stay requirement has provided CMS with ample evidence to review the efficacy and necessity of existing SNF coverage requirements. Both clinicians and patients have benefitted from the relaxation of this requirement, as beneficiaries get the care they need and deserve without unexpected costs, and clinicians are trusted to provide care based on clinical evidence, rather than an outdated time-based policy.

Hospital Transfers: Prior Authorization Relaxation

[4] Sheehy AM, Powell WR, Kaiksow FA, Buckingham WR, Bartels CM, Birstler J, Yu M, Bykovskyi AG, Shi F, Kind AJH. Thirty-Day Re-observation, Chronic Re-observation, and Neighborhood Disadvantage. Mayo Clin Proc. 2020 Dec;95(12):2644-2654. doi: 10.1016/j.mayocp.2020.06.059.

In an effort to free up much needed acute care beds during the pandemic, CMS relaxed prior authorization requirements, which facilitated the rapid transition of patients from inpatient status at a tertiary care center back to the patient's home region as soon as the higher-level tertiary services were no longer required. The ability to quickly move patients between the sites freed up badly needed tertiary care beds throughout the COVID-19 pandemic. However, as prior authorization requirements were reinstated, this flexibility to move patients as needed and as clinically appropriate diminished. Hospitalists have reported that MA plans are not authorizing lateral transfers from tertiary care centers. As a result, patients are being treated in facilities with inappropriate levels of care, in some cases far from their family and community. This has also left patients boarded in emergency rooms or in facilities with limited resources while waiting for scarce tertiary bed space to open. The relaxation of prior authorization requirements during the pandemic has provided CMS with the opportunity to analyze data and hear from stakeholders about how these changes impacted care throughout the country.

Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities Recommendations

Three Day Stay Waiver

SHM urges CMS to use the experience from the COVID-19 PHE relaxation of the three-day stay rule for SNF coverage. We urge CMS to extend the three-day stay waiver beyond the expiration of the PHE and support making this exemption permanent. CMS has an opportunity and new data available to justify removing an outdated and ineffective barrier to SNF coverage and ensure patients can access the appropriate level of care without unnecessary or prolonged hospitalization.

Telehealth

SHM welcomed the addition of Category 3 to the Medicare Telehealth Services list, which allowed select services to remain eligible for telehealth reimbursement through the end of 2023. We remain strongly supportive of maintaining payment for telehealth services, including many hospital-based services, after the expiration of the PHE. This includes services contained in the Category 3 list and those falling within the 151-day period for those services not added as Category 1, 2, or 3.

We continue to urge CMS to consider adding inpatient and observation initial visit (99218-99220, 99221-99223) and hospital inpatient or observation care for the evaluation and management of a patient including admission and discharge on the same date (99234-99236) to the Medicare Telehealth list as Category 3. While these services are not delivered via telehealth across all hospital settings, the addition of these services has been important in rural and underserved hospitals. Rural hospitals with fewer resources and often inadequate staffing levels utilize telehealth admissions, particularly for night coverage, to stretch their limited resources and to ensure all beneficiaries receive appropriate care. It is important to note, however, that some patients in rural and underserved communities may lack access to Wi-Fi or technology with video capabilities. CMS must advocate for policies to ensure these patients are not left behind. We believe continuing telehealth payment for these services will enable CMS to collect more data about the use and value of these services when delivered as telehealth. We also ask CMS to make public more data around the utilization of telehealth codes to better inform stakeholders about the usage of telemedicine within the Medicare program.

Prior Authorization:
CMS should use its oversight authority over Medicare Advantage plans to address longstanding issues with prior authorization. The current prior authorization process devalues medical training and experience and adds significant administrative burdens to the healthcare system. Instead of spending time attending to clinical care, hospitalists must spend a growing amount of non-payable time navigating administrative hurdles, often with little-to-no advance notice, to advocate for the care their patients need and deserve. We urge CMS to use this data and experience from the COVID-19 PHE waivers to establish policies and procedures for prior authorization that ensure patient safety while preventing excessive and unnecessary care delays or denials.

Conclusion
SHM appreciates the opportunity to provide comments on the *Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs* RFI and looks forward to continuing to work with the agency on these issues. If you have any questions or require more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org.