Society of Hospital Medicine

Empowering hospitalists.
Transforming patient care.

1500 Spring Garden Street
Suite 501 • Philadelphia, PA 19130
P: 800.843.3360 • F: 267.702.2690
hospitalmedicine.org

August 10, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: CMS–6082–NC, Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork

Dear Administrator Verma,

The Society of Hospital Medicine (SHM), on behalf of the nation's hospitalists, welcomes the opportunity to provide feedback on the Request for Information (RFI) on the Reducing Administrative Burden to Put Patients Over Paperwork Initiative. We share a desire to decrease administrative burden while ensuring patients receive high quality medical care.

Hospitalists are front-line clinicians in America's acute care hospitals whose professional focus is the general medical care of hospitalized patients. Their position in the healthcare system affords hospitalists a distinct perspective and systems-based approach to solving problems at the individual provider and overall institutional level of the hospital. In this capacity, hospitalists not only manage the inpatient clinical care of their patients, but also work to enhance the performance of their hospitals and health systems. They provide care for millions of patients each year, including a large majority of hospitalized Medicare beneficiaries, and are national leaders in quality improvement, resource stewardship, and care coordination.

Excessive administrative requirements redirect finite resources away from patient care. Rather than focusing first and foremost on direct patient care, hospitalists often find themselves inundated with burdensome regulatory and administrative requirements. As such, hospitalists are uniquely positioned to comment on meaningful areas in which CMS can work to reduce excessive administrative burden.

Observation Care: A Source of Significant Administrative Burden and Hidden Costs

Medicare's observation care policies are a clear example of outdated policies that continue to require extensive administrative resources, stifle innovation, and impede patient care. Since 2013, the Centers for Medicare and Medicaid Services (CMS) has required that hospital stays less than two midnights long, with few exceptions, be billed as observation. Medicare considers observation care to be an outpatient status, even though these services are provided within the hospital walls, and in many cases, observation is virtually indistinguishable from care provided to inpatients. Since observation care and inpatient admissions are billed under different payment systems (Medicare Part B and Part A, respectively), providers must prospectively predict how long patients will need to stay in the hospital in order to bill for observation services. While the two-midnight rule was established to prevent overly long observation stays, it is unrealistic to expect providers to accurately predict the length of patient stay upon admission and to be distracted by the potential for status changes as a hospital stay develops.

Navigating the rules around inpatient admissions and outpatient observation care requires a significant shift of healthcare resources away from direct patient care. Hospitalists report that, in addition to themselves as the direct healthcare provider, status determinations between inpatient admissions and outpatient observation care require the input of a myriad of staff including nursing, coding/compliance teams, utilization review, case managers and external review organizations.[1] A recent study in the *Journal of Hospital Medicine* indicated that an average of 5.1 full time employees, not including case managers, are required to navigate the audit and appeals process associated with hospital stay status determinations.[2] Another recent study in *Professional Case Management* indicated "hospital case managers' time is inordinately leveraged by issues related to observation status/leveling of patients and Centers for Medicare and Medicaid Services compliance. The data also suggest that hospital case management has taken a conceptual trajectory that has deviated significantly from what was initially conceived (quality, advocacy, and care coordination) and what is publicly purported."[3] Instead of improving care quality and helping patients, case managers are spending their time on status determinations. This is a misuse of resources and demonstrates that outdated observation policies increase administrative costs without improving patient care. Numerous resources, including staff, time, and money, are directed away from patient care and quality improvement efforts (such as novel transitions programs, communication, and coordination of care) to ensure compliance with these outdated Medicare policies.

Additionally, time spent under observation does not count towards the three-midnight hospital stay needed to qualify for Medicare Skilled Nursing Facility (SNF) coverage. The appendix in SHM's *The*

---

[1] Society of Hospital Medicine. The Hospital Observation Care Problem: Perspectives and Solutions from the Society of Hospital Medicine. September 2017. Accessed July 23, 2018 via https://www.hospitalmedicine.org/globalassets/policy-and-advocacy/advocacy-pdf/shms-observation-white-paper-2017.

[2] Sheehy AM, et al. Recovery audit contractor audits and appeals at three academic medical centers. J Hosp. Med. 2015 Apr;10(4):212-219.

[3] Reynolds JJ. Another Look at Roles and Functions. Has Hospital Case Management Lost Its Way? Prof. Case Mgmt. 2013 Sept./Oct.; 18(5):246-254.

Hospital Observation Care Problem white paper ("Observation Time Never Counts Towards SNF Coverage") diagrams how under current rules, even four- and five-day long hospital stays may not grant patients access to Medicare SNF coverage.[4] Instead of focusing on providing patients with the appropriate level of care, patients and providers must navigate uncertain and confusing observation policy. When patients do not qualify for necessary SNF care, patients must determine whether to pay out-of-pocket or forego needed care. In our experience, this fraught decision pits patient finances against their health and well-being. This can ultimately lead to costly consequences, including readmissions, preventable complications, and degradation of patient's health status, costing both patients and the healthcare system. SNF coverage should be dictated by the clinical needs of the patients, rather than an arbitrary inpatient length of stay. In addition to revising observation policy, CMS must change the SNF coverage policy to ensure patients are getting the right care in the right setting, at the right time.

We should also note that the purpose and intent of observation care has shifted over time. When Medicare was first created, the average length of a hospital stay was approximately nine days for the general population and 14.2 days for those age 65 and older.[5,6] Observation care was "a well-defined set of specific, clinically appropriate services, which include[d]… treatment, assessment, and reassessment whether patients w[ould] require further treatment as hospital inpatients or if they [would] be discharged from the hospital..."[7] When the average length of stay spanned between 9 and 14 days, the structure of observation care ensured providers had adequate time to determine the level of care patients' required. Today the average length of stay is about 4.6 days, and many modern hospitalizations are reimbursed entirely as observation services. [8] Medicare rules developed 54 years ago are no longer relevant to current clinical realities and the strides we have made in shortening the length of a hospital stay. Observation care policy must be updated because Medicare rules developed 54 years ago do not work in today's health care environment. Not only will updated policy reduce unnecessary administrative burden and help physicians return their focus to practicing medicine, but it will also ensure patients are able to receive needed medical care.

Medicare Advantage (MA) plans create increased burden and complication surrounding observation care policy. MA plans do not have to follow the two-midnight rule and often use entirely different criteria to determine whether a patient should be admitted as an inpatient or placed under observation.

---

[4] Society of Hospital Medicine. The Hospital Observation Care Problem: Perspectives and Solutions from the Society of Hospital Medicine. September 2017. Accessed July 23, 2018 via https://www.hospitalmedicine.org/globalassets/policy-and-advocacy/advocacy-pdf/shms-observation-white-paper-2017.

[5] U.S. Bureau of the Census. Statistical Abstract of the United States, 1966. 87th Annual Edition. Washington, DC: 1966.

[6] Loewenstein R. Early effects of Medicare on the health care of the aged. Available at: https://www.ssa.gov/policy/docs/ssb/v34n4/v34n4p3.pdf.

[7] Centers for Medicare & Medicaid Services. (2014). Medicare Benefit Policy Manual, Chapter 6: Hospital Services Covered under Part B. (CMS Publication Rev. 182). Baltimore, MD

[8] Freeman WJ, Weiss AJ, and Heslin KC. "Overview of U.S. Hospital Stays in 2016: Variation by Geographic Region." Agency for Healthcare Research and Quality: Healthcare Cost and Utilization Project. Accessed via https://www.hcup-us.ahrq.gov/reports/statbriefs/sb246-Geographic-Variation-Hospital-Stays.jsp.

The inconsistent admissions criteria between MA plans and traditional Medicare plans further complicates the admissions process and increases administrative burden and expense.

The "observation versus inpatient" decision is a payment policy irreflective of patient care. It requires vast amounts of administrative burden and yields no clinical benefit.[9] We believe CMS should consider eliminating the contradiction of "outpatient hospitalizations" in its Patients Over Paperwork initiative so physicians and other workforce tied up in billing determinations can focus on patient care.

The 96-Hour Rule: A Burden in Rural Settings with Real Negative Consequences

We support CMS' effort to reduce administrative burden, particularly in rural settings, and the 96-hour rule is another clear example of an overly burdensome, outdated administrative rule. Critical Access Hospitals (CAH) must meet an annual patient length of stay (LOS) average of 96 hours or less. The 96-hour payment rule also requires providers to certify, with reasonable certainty, that an individual patient should expect to be discharged or admitted to another hospital within 96 hours or less. It is unrealistic to expect providers to predict a patient's LOS with that degree of accuracy. Furthermore, an individual patient in a CAH can exceed 96 hours of hospitalization without impacting the hospital's CAH status, so long as the hospital annual average LOS does not exceed 96 hours. As such, certifying expected patient LOS is unnecessary, administratively burdensome, and does not serve to improve the quality of patient care.

The 96-hour rule can also act as a barrier to patients' access to timely and quality care. For example, one of our members works at a CAH in Bishop, CA, and she described her frustrations with the 96-hour rule. If she or her colleagues cannot determine with relative certainty that a patient will not exceed 96 hours in the hospital, they must transfer the patient to another hospital. However, the nearest receiving facility is approximately 200 miles away. The three-and-a-half-hour drive is frequently impassable in the winter, in which case the arrangement of extremely costly air transportation is required. In short, the 96-hour rule encourages costly, and often unnecessary, transfers to tertiary care centers.

In rural America, many, if not most, patients are elderly and, reasonably, do not want to be sent out of their community. Trying to care for these patients in under 96 hours is a challenge. In addition, patients often do not want aggressive care that would be offered upon transfer and therefore refuse transfer altogether. Unnecessary transfers to tertiary care centers also result in patients being separated from their homes, communities, and support systems, increasing stress associated with hospitalizations.

Due to the unique CAH payment structure, the 96-hour rule was created guard against increased costs to Medicare as a result of keeping patients hospitalized within the CAH payment structure. Instead of protecting Medicare's financial solvency, the 96-hour rule produces unnecessary and costly

[9] Ann M. Sheehy, Charles F. S. Locke, Bradley Flansbaum "What The Inspector General Gets Wrong About Reforming Observation Hospital Care, " Health Affairs Blog, March 25, 2019. DOI: 10.1377/hblog20190320.244258

administrative requirements that do not benefit patients. Rural health care access is limited and continues to contract due to facility closures and a lack of resources, and the 96-hour rule redirects already limited resources away from direct patient care. We believe the 96-hour rule should be eliminated so that the nation's critical access hospitals and the providers within them may care for patients appropriately and efficiently.

Medicare Advantage Plans: Standardize to Minimize Burden and Establish Consistency

Medicare Advantage (MA) Plans are designed to provide seniors with health insurance options to fit their lifestyle and coverage needs. However, the lack of standardized rules and coverage within the various MA plans creates significant burden and confusion for providers. Additionally, the lack of standardization creates unnecessary, and sometimes dangerous, delays to patient care.

For example, skilled nursing facility (SNF) admission requirements demonstrate these inconsistencies. To qualify for SNF coverage some MA plans require patients to receive both physical and occupational therapy, while other plans only require one service. Other plans may require a physician-to-physician phone call for justification for post-acute placement. The resulting confusion about what each of the many plans require can result in transfers back to the sending facility or delaying transfers until requirements are met. Additionally, some MA plans require pre-authorization for many health care services, which sometimes leads to lengthy and potentially dangerous delays in care.

Providers and case managers are forced to navigate these inconsistent and often burdensome coverage requirements. We believe CMS should create rules to help standardize MA plans and govern the appeals process. This will reduce burden while improving patient care and satisfaction.

Standardizing Medicaid to Reduce Administrative Burden

Similar to our concerns with MA plans, coverage and Medicaid programs in the states vary widely between states and, in states contracting with multiple private insurance plans, within states. This results in providers needing to know and manage different rules for formularies and services covered. With so much variation, providers are spending increasing amounts of clinical time navigating and engaging in patient advocacy with these plans instead of providing direct patient care. We encourage CMS to explore ways to increase standardization in Medicaid plans across and within states.

Reviewing the Necessity and Benefit of Documentation Requirements

Much of the administrative burden in the healthcare system stems from documentation requirements to control coverage and reimbursement. Many of these documentation requirements were developed prior to the widespread implementation of EHR systems and have not been updated to address changing trends in healthcare. Many face to face forms, such as those for home health services, physician certification on home health paperwork, physician countersignatures for documentation by

advance practice providers (APPs), yearly refreshing of HCC diagnoses for chronic diseases or permanent conditions, and forms associated with home oxygen, durable medical equipment, and ambulance transport, for example, are demonstrative of paperwork that take away from clinical time without providing clear benefit. While each form in isolation may be relatively low burden and, in some cases, intended to prevent possible fraud, there as currently so many mandated forms that more time is spent on navigating and completing requisite forms than on caring for patients. We recommend CMS undertake a systematic review of forms and certifications required for coverage and reimbursement. This review should focus on streamlining documentation and using information already documented in the electronic medical record.

Creative Testing of Models and Processes to Improve Quality and Simplify Documentation Burden

We believe the Center for Medicare and Medicaid Innovation (CMMI) is uniquely empowered to help drive burden reduction and quality improvement. Hospitalists were major participants in the Bundled Payments for Care Improvement (BPCI) program and are actively engaged with the current Bundled Payments for Care Improvement-Advanced (BPCI-A) alternative payment model. After seeing successes in these models, we believe there are opportunities to expand bundled payments beyond procedures and diagnoses. As a variant to BPCI-A or other bundling demonstration, CMS could develop a model centered around general medical hospitalizations to eliminate large amounts of documentation burden while using cost and quality metrics to prevent overutilization or decreased quality. For example, hospital admissions from which medical diagnoses will be primary, CMS could pay a 95% blended cap rate for daily hospital medicine care, while controlling for outliers and monitoring cost and quality indicators (outliers could be controlled for and cost/quality would be closely monitored). In exchange, CMS could require less or even eliminate some of the documentation requirements around items such as Review of Systems (ROS) Overview, Physical Exams, redundant Patient Medical History (PMHx), and non-germane Family History (FHx). This would enable providers to receive consistent payments while significantly reducing their administrative paperwork.

CMS should also look at ways to simplify, standardize, and reduce wasted efforts when it comes to Electronic Medical Record (EMR)documentation and coding. For the inpatient setting, in particular, the variability in note quality, brevity, utility, and compliance is astonishing. Issues like note bloat, copy and paste redundancies, and difficulty identifying relevant clinical information are widespread. For example, hospitalists report commonly seeing 15-page notes from the emergency department with more than 3 pages of medications that a patient isn't even taking anymore, still listed as active. This low-quality documentation has patient care implications, is exceedingly time-consuming to sort through, and can have adverse financial implications for hospitals. To help remedy some of these issues, CMS should consider working toward standardizing EMR templates or at least clarify expectations on the narrative portions of notes. Much of the promise of an EMR's utility to capture this information is being lost due to the high variability in EMR note quality.

Conclusion

SHM greatly appreciates the opportunity to provide feedback and perspectives to CMS on the Patients Over Paperwork Initiative. If we can provide more information, please contact Josh Boswell, General Counsel and Director of Government Relations, at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Chris Frost, MD, SFHM
President
Society of Hospital Medicine