Society of Hospital Medicine
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June 14, 2024

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The Society of Hospital Medicine (SHM), representing the nation's more than 46,000 hospitalists, is pleased to offer our comments on the *Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B* white paper. Hospitalists are physicians whose professional focus is the general medical care of hospitalized patients. They provide care to millions of Medicare beneficiaries each year, often caring for medically complex patients with compounding, complex, and chronic conditions. It is from this perspective that we offer our comments on urgently needed reforms to the Medicare physician payment system.

We offer comments on the specific questions under consideration in the white paper and additional general comments on the Medicare physician fee schedule (PFS) below.

Addressing Payment Update Adequacy and Stability

Question: As an alternative to the current-law updates, how should the CF be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?

SHM continues to be concerned with the state of current-law updates to the Medicare PFS. Under the MACRA statute, there is a small differential for participants in advanced alternative payment models (A-APMs) and non-participants (0.75% vs 0.25%). These updates are not tied to inflation, which has had a significant impact on physician payment in the last three years. In addition, Congress has acted numerous times since the passage of MACRA to provide one-off and short-term stabilization to payments in the PFS and update

the CF to counterbalance some or all of cuts to physician payments slated to go into effect. Neither of these approaches create sustainability or consistency in the Medicare PFS.

Physician reimbursements do not include inflationary updates. The PFS is also the only payment system in Medicare not tied to any sort of inflation-based adjustments. As inflation has continued to rise, physician reimbursement rates lag further and further behind the real cost of care. According to an estimate from the American Medical Association (AMA), physician payment has effectively declined 26% since 2001.[i] The failure to keep pace with inflation has direct impacts on patient care. Lower reimbursement rates make it difficult to attract and retain a quality workforce, contributing to staffing shortages. Furthermore, many healthcare systems are still recovering from the financial and staffing fallout from the COVID-19 PHE. To better support patients and provide the care they need and deserve, physician payment rates must reflect the realities of inflation and the real costs of patient care.

Congressional action is needed to alleviate the significant payment cut that has resulted from inflationary increases. SHM supports the Strengthening Medicare for Patients and Providers Act (H.R. 2474). This legislation would provide physicians with an annual, permanent payment update in Medicare tied to the Medicare Economic Index. This will help ensure physicians are reimbursed at a rate reflective of real care costs, thus ensuring patients have access to the highest quality care.

Regular inflation-based updates will also allow Congress to focus on other pressing healthcare reforms. Annual cuts are devastating to patient care – and distract from other, pressing healthcare reforms. Instead of focusing on how to improve care quality, lower costs, combat health disparities, and reduce clinician administrative burden, Congress redirects its focus on temporary payment fixes and partial payment cut relief. This cycle repeats each year, sometimes multiple times in a single year. Passing H.R. 2474, on the other hand, will help ensure stability in physician payment rates, freeing up Congress to direct its focus on other pressing healthcare needs.

Question: Current law updates reflect a differential between A-APMs and non-participants. How, if at all, should a new CF framework reflect participation in A-APMs as an incentive for participation?

SHM has consistently supported incentivizing participation in A-APMs and moving away from a fee-for-service payment system. Throughout MACRA's implementation, we provided critical feedback about limitations of the APM qualifying participant (QP) and partial QP designation thresholds, which created barriers for APM participants to receive incentive payments. We also repeatedly raised concern that the dearth of available APMs for clinician participation are another, and often insurmountable, barrier preventing the transition to APMs. These barriers dramatically inhibit the utility of the current law update differentials. If most clinicians are not able to meet QP eligibility standards due to structural impediments, a slightly higher CF update percentage can do nothing to incentivize participation. We strongly urge Congress to address these upstream challenges to QP status as part of comprehensive incentive package for APM adoption.

Some hospital medicine groups were early and enthusiastic adopters of CMMI models like the Bundled Payments for Care Improvement (BPCI) and BPCI Advanced. To be successful in these programs, they invested significant financial and staff resources into the implementation of these bundles. We believe a

component of redesigned incentives for APM participation should include some form of compensation or allowance for up-front costs associated with implementing a new model. At a minimum, the investment in both time and resources for model participation should be considered when evaluating at-risk models.

Addressing Concerns Regarding Budget Neutrality in the PFS

Questions: What policies, if any, would help to address inaccurate utilization assumptions that trigger budget-neutrality adjustments, or else account for said assumptions in subsequent rate-setting processes? Should the Committee consider additional parameters to align the statute's budget-neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?

All changes within the PFS are required to be budget neutral, meaning that increased reimbursement for some services necessitate reduced reimbursement for others. While budget neutrality is designed to guard against excessive increased costs and protect the financial health of Medicare, it has also resulted in devaluing select services in favor of others. Furthermore, budget neutrality fails to recognize that delivering high quality care comes at a cost. As the costs of healthcare delivery have increased, it has become increasingly difficult to provide the necessary care and staffing under the current financial limitations.

The white paper highlights several recent instances of CMS' overestimation of utilization for new or amended codes in the PFS, including Transitional Care Management (TCM) and Chronic Care Management (CCM) codes. The high utilization estimates resulted in required reductions to the CF due to budget neutrality requirements. We also note there is a high potential for a similar overestimation on utilization of the new office/outpatient Evaluation & Management visit complexity add-on code (G2211) started this year. Unfortunately, overestimates that result in large cuts to the CF are not recouped in future PFS years. Instead, that money is eliminated from the payment system.

SHM strongly supports H.R. 6371, the Provider Reimbursement Stability Act of 2023, which would increase the threshold at which budget neutrality requirements go into effect. It would also create a mechanism for the Secretary of Health and Human Services to correct inaccurate estimations that impact the CF. We believe these reforms are necessary to better stabilize the payment system and prevent dramatic shifts caused by budget neutrality requirements.

Incentivizing Participation in Alternative Payment Models (APM)

One of the largest barriers to APM participation is the lack of available models for clinicians to elect. The MACRA statute created a Physician-Focused Payment Model Technical Advisory Committee (PTAC) in order to make recommendations to CMS on payment models. To date, no models that have been reviewed by PTAC have been tested by CMMI. This lack of movement on submitted models has also stalled momentum on developing new models by healthcare stakeholders, effectively capping the APM pipeline. Without models that are relevant to clinicians, incentives will not be able to drive participation in APMs and, ultimately, move the payment system away from fee for service.

Question: Should the bonus continue to require participation thresholds, or modify or eliminate thresholds to allow for greater participation? How?

While SHM remains supportive of the intention to encourage a shift away from fee-for-service (FFS) Medicare towards APMs that prioritize quality care, the availability and adoption of APMs remains limited. Participation thresholds remain a significant barrier for APM participation. SHM encourages the Committee to consider alternatives to thresholds for participation, which can leave clinicians with significant uncertainty year-over-year whether they are QP status. High participation thresholds also necessitate planning for participation in their selected APM as well as contingency planning for MIPS participation. If they cannot reliably expect to be considered an APM participant, they must also be prepared to report in the MIPS. While CMS' APM Participation Pathway in the MIPS does ease some of that burden, we believe more can be done to relieve groups participating in APMs from the burden of MIPS participation.

There are two general APM structures that CMMI has tested: episode-based and broad patient relationship-based. Episode-based models, like BPCI and BPCI-Advanced, are structured around specific episodes of care. Hospitalists' experiences have shown that models built around specific clinical conditions create challenges in meeting the participation thresholds for providers like hospitalists who have a heterogeneous clinical workload. On the other hand, many hospitalists work in health systems that are part of ACOs, which are more broad-based patient relationship models. Hospitalists, who would not be the clinicians associated with beneficiary assignment to the ACO, have had challenges being included on participation lists and therefore potentially eligible for QP status if the ACO meets the thresholds. These experiences tell us that identifying APM participation is difficult at the provider level, and current rules do not adequately capture clinician involvement.

Rethinking the Merit-based Incentive Payment System (MIPS)

Congress authorized CMS to develop a program to assess and incentivize increased care quality and efficiency while encouraging movement towards APMs. This program was eventually called the Merit-based Incentive Payment System (MIPS). It aims to pay for value by judging clinicians and groups across four categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. While this goal is laudable, the MIPS is not a success. It has created extensive administrative burden and redirected limited resources away from patient care with clearly impacting quality or costs. A 2022 study from JAMA concluded the MIPS program may be "ineffective at measuring quality improvement among physicians."[ii] Unfortunately, MIPS is the only program available for a significant number of clinicians and groups.

Participation in the MIPS is particularly challenging for hospitalists, as there are very few relevant quality measures on which they can report. Specifically, they have four measures in their MIPS specialty set. Two of the measures are broad-based (Advance Care Plan Quality#047 and Documentation of Current Medications in the Medical Record Quality#130) and two are specific to heart failure (Quality#005 and 008). These measures do not represent the heterogeneity of hospitalized patients or the scope of hospitalists' clinical expertise and responsibilities. As measures are topped out and removed from the

program, hospitalists will have even fewer measures available to report. In general, cost measures are not aligned with quality measures. As such, it is difficult to assess the "value" of care while looking at cost measures unrelated to the quality measures available for hospitalists.

We have consistently advocated for better coordination between hospital and clinician-level programs at CMS, given the work of hospitalists and hospitals is intertwined. We appreciate that Congress and CMS created a pathway within the MIPS for using facility-level measures in the MIPS. We believe aligning quality goals between providers and their institutions has the potential to streamline CMS' programs for many clinicians, even beyond hospitalists. However, more work needs to be done to balance the simplicity of the facility-based measurement option while simultaneously ensuring individual clinicians and groups, which is the level of measurement of the MIPS, are assessed on measures they can control or influence. Currently, the MIPS facility-based measurement option allows eligible clinicians and groups to receive a score in the MIPS based on their attributed hospital's Hospital Value-Based Purchasing (HVBP) score. The HVBP contains a range of measures, some of which hospitalists are already held accountable for by their institutions, and some which are well beyond the clinical scope of services provided by hospitalists. The facility-based measurement option could be improved by allowing and encouraging CMS to use individual measures from other programs for individual or group performance in the MIPS.

Improving Primary Care and Chronic Care

The white paper asks a number of questions about improving chronic care, particularly in the primary care setting. Although hospitalists practice in hospitals, many of their patients have chronic conditions that require care and maintenance in addition to their acute care needs. While the management of chronic conditions is best performed in the outpatient setting, the hospital remains important to the care of chronic conditions. Past efforts to improve primary care and increase payment for primary care and chronic care services have triggered budget neutrality. These payment increases resulted in across-the-board cuts to the PFS, which disproportionately impacted non-primary care services. This zero-sum approach is damaging to the healthcare system and risks creating deficits in other parts of the care continuum for patients with chronic conditions. We urge the committee to work on preventing harmful cuts to the healthcare system as they work to improve primary and chronic care.

Ensuring Beneficiaries' Continued Access to Telehealth

Telehealth services were rapidly expanded during the COVID-19 pandemic in an effort to keep both patients and clinicians safe. Increased telehealth flexibility has become an important tool to provide quality care for patients, particularly those in rural or underserved communities. However, the upcoming expiration of many telehealth flexibilities will interrupt and negatively impact patient care. We support permanently adding the hospital inpatient or observation care admission codes (99221, 99222, 99223), hospital inpatient or observation care admit/discharge same date codes (99234, 99235, 99236), and hospital inpatient or observation discharge codes (99238, 99239) to the Medicare Telehealth eligible services list.

While these services are not delivered via telehealth across all hospital settings, they are important in rural and underserved hospitals. For example, rural hospitals, many of which have fewer resources and inadequate staffing levels, utilize telehealth admissions, particularly for night coverage, to stretch their limited resources and to ensure all beneficiaries receive the care they need and deserve. We believe the past several years of increased telehealth usage has provided CMS and Congress with valuable data about the usage and quality of care provided via telehealth. We also support increasing public access to telehealth utilization to better inform stakeholders about the usage of telemedicine within the Medicare program.

Conclusion

SHM appreciates the opportunity to provide comments on *Bolstering Chronic Care through Physician Payment* white paper. We look forward to continuing to work with the Committee to address this important issue. If you have any questions, please contact Josh Boswell, SHM director of Government Relations and Chief Legal Officer at jboswell@hospitalmedicine.org.

Sincerely,

Flora Kisuule, MD, MPH, SFHM
President, Society of Hospital Medicine

Society of Hospital Medicine

[i] https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-fell-26-2001-how-did-we-get-here

[ii] https://jamanetwork.com/journals/jama/fullarticle/2799153