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Dear Representatives Bera, Buschon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks,

The Society of Hospital Medicine (SHM), representing the nation's more than 44,000 hospitalists¹, greatly appreciates your interest in establishing greater financial sustainability and stability within the Medicare payment system and the healthcare system at large. We also applaud your efforts to examine implementation issues with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). While MACRA was developed to move the healthcare system away from the fee-for-service model towards value-based payment, this goal has been hampered, in part, by well-intentioned but very real barriers stemming from MACRA itself. We thank you for taking the time to solicit feedback on how to improve the program.

Hospitalists are physicians whose professional focus is the comprehensive medical care of hospitalized patients, providing care to millions of Medicare beneficiaries each year. During the deadly COVID-19 pandemic, they served their communities heroically by providing high-quality care for hospitalized patients. In addition to

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



managing clinical patient care, hospitalists also work to enhance the performance of their hospitals and health systems. The unique position of hospitalists in the healthcare system affords them a distinctive role in both individual physician-level and hospital-level performance measurement programs. Hospitalists have a range of experience with participating in the two MACRA pathways (MIPS and Advanced Alternative Payment Models (APMs)), including being major participants in the Bundled Payment for Care Improvement (BPCI) models. It is from these perspectives that we offer our comments on this Request for Information (RFI).

MACRA is Not Achieving Its Aims

SHM and hospitalists have consistently and broadly supported the goals of MACRA. We believe moving towards a value-based payment system that rewards high-quality care and good outcomes, as opposed to the volume of services provided, will lead to improved patient care and a more efficient use of resources and healthcare dollars. However, hospitalists' experiences under MACRA have shown the limitations of the program far outweigh the benefits.

For most hospitalists, MACRA, and particularly the Merit-based Incentive Payment System (MIPS), has become little more than a compliance exercise. Hospitalists rarely consider MACRA a vehicle to improve quality or patient care, and it is common that discussion of the program begins and ends with "avoiding a penalty." This is unfortunate. We believe this interpretation of the program largely stems from the reality that many measures have limited meaning and applicability to a front-line clinician's day-to-day practice. For hospitalists, there are very few relevant quality measures – it is not mathematically possible to score in the top decile because of certain measures invoking "topped out" scoring limitations. Those that are available do not reflect the heterogeneity of their work, and do not appreciably differentiate practices with better patient outcomes. Cost measures are difficult, if not impossible, to interpret and hold individual clinicians accountable for costs beyond their control. Taken together, it is understandable why front-line hospitalists do not see how their mandatory participation in the MIPS improves patient care.

Hospitalists participating in alternative payment models (APMs) have had mixed experiences. While participants appreciate the concerted effort towards creating a value-based payment system, the lack of applicable APMs, difficulty and expense of entry, and the nearly impossible-to-meet thresholds that must be met to realize any incentive has served to discourage participation. Hospitalists and hospital medicine groups were at the forefront of participation in Bundle Payments for Care Improvement (BPCI) and Bundled Payments for Care Improvement Advanced (BPCI-A). Their work on developing the care pathways and models to meet the requirements and goals of BPCI and BPCI-A did improve care for the patients in their bundles. There were significant investments in staffing, operational changes, care innovations, and information technology. Despite these investments, successes were not recognized in the MACRA Quality Payment Program or the APM incentive payment due to the statutory constraints and restrictions for qualifying participation. Changes to the pricing model led to the exit of many bundles or practices' participation altogether. Despite changes announced in October 2022, the continued inclusion of COVID-19 patients makes continued participation a high-risk, low reward scenario that is unlikely to attract or retain exiting participants.



Beyond BPCI and BPCI-A, many hospitalists care for patients in Accountable Care Organizations (ACOs) or ACO-like environments. Some of these hospitalists may have been included in CMS participation lists for these models, but many were not, leaving their work to be assessed in both the ACO and in their own reporting in the MIPS.

The overall complexity of MACRA, in both the Quality Payment Program (QPP) and APM pathways, has succeeded in diverting resources that could be devoted to direct patient care, improving care quality in other more measurable and meaningful ways, and improved staffing levels. Instead, resources have gone towards the third-party consultants, QCDRs, and program subject matter experts that are often needed to comply with program requirements. For example, hospitalist groups have reported that for many programmatic years, the costs they bore with diverted staff time, hiring consultants, securing reporting vendors, and purchasing new or add-on technologies aimed at compliance have consistently outstripped any potential QPP incentives, even when qualifying for the exceptional performance bonus.

MACRA created new administrative burdens for clinicians, requiring the tracking and reporting of a larger and ever-changing set of measures. Administrative burden is a leading cause of clinician burnout and contributes to excessive documentation and “note bloat” in electronic medical records. As the Centers for Medicare and Medicaid Services (CMS) restores much of the program to full operation after the significant COVID disruptions, clinicians are returning attention to administrative tasks such as these performance assessment activities with less professional and emotional capital.

The Transition Away from Fee for Service Has Stalled

MACRA’s aim to facilitate the transition away from fee-for-service Medicare towards new payment models that reward value has not been realized and is unlikely to do so absent significant reform. According to the Center for Medicare & Medicaid Innovation’s (CMMI) recent evaluation results across twenty-one Medicare APM models between 2012 and 2020, the results of alternative payment models are mixed.² One-third of models assessed showed negative net impact on spending, while the impact on care quality or utilization across models was more varied. More importantly, the pipeline for new models appears dry.

MACRA authorized the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to vet and make recommendations to the Department of Health and Human Services (HHS) on payment models developed by stakeholders for potential testing and inclusion as APMs. The panel, which has been meeting since 2016, has submitted reports on a range of models. As of January 2021, the PTAC has recommended 20 models for testing or implementation, yet none have been implemented.³ CMMI itself

² Findings at a Glance: Synthesis of Evaluation Results across 21 Medicare Models; 2012-2020. Center for Medicare and Medicaid Innovation. Accessed October 17, 2022 via <https://innovation.cms.gov/data-and-reports/2022/wp-eval-synthesis-21models-aag>

³ The Physician-Focused Payment Model Technical Advisory Committee: Charting Future Directions. Office of the Assistant Secretary for Planning and Evaluation. Accessed October 17,



develops models, but many clinicians still cannot meaningfully participate in any of them and those who are participating cannot reliably meet thresholds for qualifying participation and exclusion from the MIPS.

CMS' published data about the 2022 APM incentive payments (2020 performance) highlight the challenges with meeting the QP thresholds, particularly for episode-based payment models.⁴ BPCI Advanced had an average payment threshold score of 4.24 and average patient threshold score of 3.58, when the MACRA imposed performance thresholds were 50 and 35, respectively. More cross cutting models like ACOs did not always fare better. The Medicare Shared Savings Program average scores were 46.42 and 45.18, with the average only exceeding the patient threshold. While other models performed better, those models are not necessarily applicable for all clinicians and specialties. In 2023, the payment threshold increases to 75% of payment, making QP status even more out of reach. Without significant changes, the APM pathway will remain inaccessible for many parts of the healthcare system.

MIPS is One-Size-Fits-All; Medicine is Not

Despite having a plethora of measures and activities, the Merit-based Incentive Payment System (MIPS) is a one-size fits all program that does not adequately reflect the diversity of clinicians who participate in Medicare and their different practice environments. Our understanding is that the MIPS sought to develop tailored measures for assessing performance, leading to improvements in outcomes, efficiency, and safety. The pre-MACRA successes in surgical and procedural quality and safety appeared to be a model that could be applied to the entirety of the healthcare system. Ultimately, it has been much more difficult to realize these goals, particularly for medical episodes of care performed by hospitalists.

Hospitalists practice in the hospital, which has its own set of pay-for-performance programs and measures. Some hospitalists are directly employed by their hospital or health system; others are employed by staffing and management companies; still others operate independent practices or have some other employment arrangement. Hospitalists are commonly incentivized or held accountable by their employer or hospital for hospital-level measures that are beyond the hospitalists' control. The MIPS has required several legislative or regulatory corrections to prevent facility-based providers from being held accountable for facility-level measures. For example, hospitalists are exempt from the Promoting Interoperability (formerly Advancing Care Information) category of the MIPS. This is because their hospital operates the electronic health record they use and the hospital is required to meet its own hospital-level requirements.

Following SHM's advocacy efforts, CMS recognized that the work of hospitalists is also assessed in hospital-level metrics and developed a facility-based measurement option that enables hospitalists to receive a score based on their hospital's Hospital Value-Based Purchasing (HVBP) program score. This

2022 via <https://aspe.hhs.gov/sites/default/files/private/aspe-files/207901/aspe-charting-future-directions-ptac.pdf>

⁴ Advanced Alternative Payment Model (APM) Incentive Payments for 2022. CMS Quality Payment Program Resource Library. <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1997/QP%20Count%20and%20Incentive%20Payments.pdf>



was only possible because of a specific statutory provision SHM advocated for that enabled the use of other program measures in the MIPS. While facility-based measurement provides an alternative pathway for hospitalists' participation in the MIPS, it still has attribution issues that are heightened by financial risk associated with the MIPS. Many hospitalist groups are uncomfortable with being held financially accountable in the MIPS for a hospital's total HVBP score and the entirety of that program's measures, because several of the individual components of the composite measures are not relevant to their practice, or that of any other QP.

Most MIPS measures are tailored either to specialty care, which has a smaller universe of procedures and conditions, or outpatient office-based care, where patient interactions are more contained in episodes of care or longitudinal relationships. Medical care in the hospital, on the other hand, is significantly more discontinuous. Throughout one patient's stay there could be interactions with numerous hospitalists, specialists, and other healthcare workers. Additionally, hospitalists see a wide range of diseases and conditions, making it difficult to develop measures that apply to most of their patients or day-to-day work. As CMS begins to move towards MIPS Value Pathways (MVPs) for participating in the MIPS, hospitalists are again being left behind. There is no applicable MVP in which hospitalists could participate fully, nor is there a realistic path to create a hospitalist MVP. This is remarkable given that hospitalists admit and care for approximately 50% of all beneficiary hospitalizations.

Hospital Patient Care is a Team-Based Sport; MACRA Does Not Recognize This

A significant tension between the structure of MACRA and the reality of hospitalist practice is that the financial risks and rewards fall on the individual clinician or group. Improving inpatient care quality, on the other hand, involves increasingly collaborative teams of clinicians across specialties and disparate group/employment structures caring for the same patients. MACRA's requirement to attribute performance on a measure or set of measures to an individual clinician or a single group is challenging and irreflective of the realities of inpatient care. This dynamic leads to widespread disengagement and fosters the perception of MACRA as a compliance exercise resulting in increased administrative burden but not an improvement in patient care.

SHM's Performance Measurement and Reporting Committee regularly reviews and provides comments on quality measures across Medicare's programs, including the MIPS. A common theme echoed repeatedly in their comments is many measures that should be relevant to hospitalist practice are not applicable because attributing performance on a measure to a single clinician for the purposes of payment adjustment is inappropriate. Group attribution is also flawed and may not account for valuable contributions of other clinical staff in the hospital. Other hospital staff may not bill Medicare for their contributions to the care of a patient but maintain a large role in determining patient and metric performance outcomes. For example, 30-day readmissions is a CMS-calculated claims-based measure that is part of the MIPS Quality category score for many hospitalists. Readmissions, particularly in the first few days post-discharge, may be influenced by decisions and behaviors by clinical staff in the hospital. However, readmissions are also influenced by external factors outside of the clinician's care, such as the availability and quality of outpatient care and decisions by patients and their caregiver. The



attribution for the readmission measure assigns responsibility and accountability to a clinician or group, regardless of the extent to which they can prevent a readmission.

APMs, in theory, should be able to transcend some of these attribution issues rampant in the MIPS measures. In practice, APMs and the measures in those models have similar pitfalls. APMs largely use the same measures available in the MIPS. For example, the Medicare Shared Savings Program uses the same set of measures that are available to groups for MIPS reporting. While advanced APMs can use any “measures comparable to the MIPS,” MIPS measures are common throughout APM models.

Team-based care is critical for patient care, particularly in the hospital setting. For hospitalized patients, the team of clinicians includes hospitalists, nurse practitioners, physician assistants, nurses, consulting specialties, social workers, case workers, techs, and non-clinical staff. We strongly encourage any reforms to keep in mind team-based care as part of future programmatic structures.

The MACRA Payment System is Unsustainable, Particularly with Inflation

At this point, CMS has met most of MACRA’s statutory requirements for the program. The program has begun to shift into the gap year where incentives for APM participation disappear and subsequent updates to the Medicare PFS are modest. The 5% incentive payment for APM participation stops with performance year 2022/payment year 2024, and the variable PFS update of 0.75% for QP status in APMs does not begin until 2024 performance/2026 payment year. MIPS participants and other clinicians would only receive a 0.25% update at that time. The gap year and the extremely modest scheduled updates to the PFS have left clinicians farther and farther behind other Medicare fee schedules that have inflation-based increases.

We recognize this aspect of the program was designed with the intent to push clinicians into APM participation, but without any realistic options for many to move to, functionally, clinicians in the Medicare program will receive significant pay cuts in the real-world value of their reimbursements.

Recommendations

Design a program for the healthcare system we need: Team-based, coordinated care.

The healthcare system works best when it is coordinated and seamless across settings and among clinicians. In many ways, MACRA has reinforced siloes in the healthcare system and pitted clinicians against each other. By focusing payments on individual clinicians or groups, MACRA created competition for scarce quality improvement resources. A new program needs to recognize and find a way to assess team-based care, accept differing practice patterns and locations of practice, and recognize varied employment structures.

Reduce duplication across the Medicare program.

Medicare has measurement programs for all its payment systems. For hospitalists, their performance is measured in hospital-level programs, as well as within clinician-level MACRA programs. This redundancy creates a perception of being “over-measured.” Furthermore, certain APMs, like ACOs, commonly



operate at the hospital- or system-level, despite MACRA trying to incentivize individual clinician or group involvement. Congress should work towards eliminating the siloes within the Medicare program and streamline reporting requirements.

Reduce administrative and documentation burden.

Hospitalists regularly report administrative and documentation tasks occupy an increasingly large portion of their workday, reducing their bedside and other clinical time. Administrative burden is consistently cited as one of the highest causes of burnout among healthcare professionals. Congress must prioritize reducing administrative workload as part of reform efforts and seek solutions that do not threaten further damage to the clinical workforce.

Consider how MACRA widens the healthcare resource gap.

Rural and small practices have consistently struggled with performance in MACRA, even with special policies in the statute and regulations designed to support their participation. Because successful participation requires resources—expertise, staffing, time, and significant investment of capital—to collect data, report on measures, and implement performance improvement, those clinicians and groups with fewer resources will face challenges to being successful. While actual differences in quality of care must be addressed, poor performance due to resource-based difficulties with reporting and programmatic compliance, particularly in under-resourced areas, cannot be ignored. If poor performance in the program is related to scarce resources, financial penalties may only result in future worsening of performance. We urge Congress to keep in mind how a budget-neutral pay for performance program may exacerbate healthcare inequities and strongly encourage the development of policies to ensure that patients can access high-quality, affordable care anywhere in the country.

Focus on measuring what matters: Improving patient outcomes and care.

Often the measures that matter most to patients are those that cannot be easily attributed to a single clinician. This reality is in direct conflict with the measurement goals of MACRA which are more focused on individual accountability and individual payment adjustments. However, these measures require collaboration across multiple disciplines and sectors of the healthcare system, encompassing both hospital-based care, outpatient care, community-based services, and governmental stakeholders. Therefore, population health measures may not be an accurate indicator of an individual clinician's or group's performance. Congress should encourage the identification of measures and other programmatic levers to encourage real improvements in quality of care. Measures should provide meaningful, actionable feedback and serve as individual accountability tools only when appropriate.

Congress should also consider building enough flexibility into what measures can be utilized so as not to disadvantage clinicians whose practice isn't suitable for the bulk of existing measures. For hospitalists, lack of relevant metrics has put them at an enormous disadvantage under both MACRA and the previous Value Based Payment Modifier where they have averaged only 2-4 measures available to them. Flexibility on how measures operate and what is measured must be established.

Identify new ways to assess participation in APMS.



MACRA’s statutory thresholds for assessing qualifying participant in APMs have been an impediment to APM participation and have disincentivized continued investment in the systems change required for APM participation. In turn, this has hampered models from realizing their true potential. Congress should reconsider how to assess APM participation and reduce barriers to the development of new and innovative payment models. This includes re-upping and redesigning eligibility for incentives for clinicians and groups to move into APMs. For example, instead of relying on a one size fits all threshold for participation as was done with MACRA, Congress could establish a “meaningful participation standard.” Such a standard might allow for looking beyond percentages of patients toward things like the investments being made, amount of restructuring that is necessary, what kind of internal incentives are being used, etc. This would allow for a greater scope and breadth of types of viable APMs, including condition specific and episodic APMs.

Learn from the impact of COVID on the healthcare system.

While much of the nation moves on from COVID-19 as an acute crisis, the healthcare system still sees a large proportion of patients with COVID-19 and is struggling to manage the pandemic’s effects on workforce burnout, staffing shortages, lack of hospital bed availability, financial distress, and other operational disruptions. These on-going issues in the healthcare system need to be addressed and should be a priority for making the healthcare system stronger. We urge Congress to explore the lessons learned from the COVID-19 pandemic and incorporate these learnings into the framework for reforming the Medicare payment system.

We are also concerned that, upon the expiration of the PHE declaration, CMS will expect participation in the QPP to return to its pre-pandemic status. CMS’ policy flexibilities during the first two years of the pandemic constituted a “pause” in the program, enabling groups to concentrate on meeting the patient care needs of their communities and addressing operational issues worsened by the pandemic. We encourage Congress to maintain flexibility for a transition period that acknowledges the current clinical and operational realities.

Conclusion

SHM appreciates the opportunity to provide feedback to this group of Congressional thought leaders. We look forward to continuing this conversation and working alongside you on continued reforms to the Medicare physician payment system. If you have any questions, please contact Josh Boswell, Chief Legal Officer/Director of Government Relations at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

A handwritten signature in black ink, appearing to read 'Rachel Thompson'.

Rachel Thompson, MD, MPH, SFHM
President, Society of Hospital Medicine