Society of Hospital Medicine
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1500 Spring Garden Street
Suite 501 • Philadelphia, PA 19130
P: 800.843.3360 • F: 267.702.2690
www.hospitalmedicine.org



September 10, 2018

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-1693-P
PO Box 8011
Baltimore, MD 21244

Dear Administrator Verma,

The Society of Hospital Medicine (SHM), on behalf of the nation's hospitalists, appreciates the opportunity to offer the following comments on the proposed rule entitled: *Medicare Program, Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019, Medicare Shared Savings program requirements, Quality Payment Program and Medicaid Promoting Interoperability Program* (CMS-1693-P).

Hospitalists are front-line healthcare providers in America's hospitals for millions of hospitalized patients each year, many of whom are Medicare and Medicaid beneficiaries. As leaders of an interdisciplinary care team, they manage the inpatient medical needs of their patients while working to enhance the performance of their hospitals and health systems.

Most hospitalists are Board Certified in Internal Medicine or Family Medicine, but practice exclusively in the hospital setting. The position of hospitalists within the healthcare system affords them a distinctive role in facilitating both the individual physician-level and hospital-level performance agendas. This includes participation and performance assessment in programs around value-based purchasing and quality improvement. This diversity of perspectives informs our comments on this proposed rule.

We are excited that CMS is proposing to implement a facility-based scoring option in the Merit-based Incentive Payment System (MIPS). We believe this reporting option is an important alternative for facility-based providers and recognizes the alignment between clinicians and their facility's quality agenda.

We offer comments below on specific proposals in the rule:

## Evaluation and Management (E&M) Visits

CMS is proposing to revise the documentation requirements associated with outpatient office Evaluation and Management (E/M) codes to allow providers

the flexibility to report 1995 documentation guidelines, 1997 documentation guidelines, Medical Decision Making (MDM), or time associated with the visit. In addition, CMS is proposing to collapse the payment associated with Levels 2 through 5 E/M codes into a single consistent payment. Although these proposals are limited to the outpatient office visit E/M codes (99201-99215), we view these proposals as setting precedent for changes to E/M codes, such as those billed in the inpatient or other facility-based settings. Therefore, we wish to indicate our broad support for reducing the documentation requirements for E/M billing and express concern over the proposed payment reforms. We also encourage CMS to view the reduction in documentation requirements as independent of any changes to the E/M payment structure.

**We are strongly supportive of CMS making changes on the documentation requirements for E/M billing and encourage CMS to pursue documentation requirement changes for E/M codes in other settings**. We believe that changes to documentation requirements would be wholeheartedly welcomed by providers. In particular, the option to use just Medical Decision Making (MDM) or time associated with the visit as the basis for documentation will give providers more flexibility, will reduce administrative burden, and ultimately, will increase the quality of patient care, as providers would be able to focus on caring for their patients instead of completing paperwork.

**We urge caution on CMS' approach for reforming E/M payments and oppose the proposal in its current form**. The proposal could lead to decreased payments for certain specialties and services and could lead to decreased access for patients. We believe CMS should work with healthcare stakeholders to develop a simplified and unified approach to these changes. A collaborative approach will ensure that the proposal does not lead to unintended consequences. While we understand and share CMS' desire to reduce complexity and burden within the healthcare payment system, this proposal has the potential for significant consequences.

**We also encourage CMS to consider inpatient and other E/M codes as part of a holistic approach to reforming E/M documentation requirements and payment structures**. We believe focusing solely on the outpatient office E/M codes will set precedents for other settings and not address the unique clinical and practice needs of those settings. By way of example, CMS should consider how to update MDM to better reflect the reality of care today and suggest that a change of note-taking formats would also be beneficial. A daily note that simply lists changes from the last visit including any problems, and a proposed plan of care, would better reflect patient care. This would be particularly useful if these E/M coding changes were to be extended to inpatient settings in future years.

## CY 2019 Updates to the Quality Payment Program

### Merit-Based Incentive System: Cost Category

**We are opposed to CMS increasing the Cost category weight to 15 percent for the 2019 performance/2021 payment adjustment year.** While we appreciate the importance of cost as a criterion to assess a clinician's performance, we do not believe it is prudent to increase the weight of this category in the same year that eight new episode-based cost measures are also being added to the category. Additionally, we have concerns that simply increasing the category weight by an additional 5 percent each year, without evaluation, could create confusion and put unnecessary stress on providers who have not yet had the opportunity to understand this category and its new measures. We acknowledge that the Bipartisan Budget Act of 2018 affords CMS flexibility on the weighting of the Cost

category for payment adjustment years two through five, but that ultimately CMS needs to weight the category at 30 percent. We suggest reevaluating the Cost domain each year for purposes of determining the proposed increase for future years.

### *Episode-Based Cost Measures*

CMS is proposing to add 8 episode-based measures in the Cost category for the 2019 MIPS performance year and future years. These episode-based cost measures were developed in collaboration with numerous stakeholders and represent an important move towards episode-based assessment in pay-for-performance programs. We reviewed the acute inpatient medical conditions measures that have the most relevance to hospital medicine: Intracranial Hemorrhage or Cerebral Infarction, Simple Pneumonia with Hospitalization, and ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI). Our comments on the general policies and specific elements of these measures are below.

*Attribution Rules for the Proposed Episode-Based Measures*

CMS proposes to use an approach centered around the Taxpayer Identification Number (TIN) for attribution to the acute inpatient medical condition measures. Cases would be attributed to each MIPS eligible clinician who bills E/M claims during a trigger hospitalization under a TIN that bills at least 30 percent of the E/M claims during the hospitalization. We share CMS' goal of prioritizing team-based care and believe this attribution methodology represents a novel approach to shared accountability. We acknowledge this methodology was tested during the Fall 2017 field testing of the measures. However, we urge CMS to remain open to feedback on unintended consequences and issues as they may arise as these new measures are implemented. For example, this methodology may attribute cases to individual clinicians who bill a single claim during the hospitalization and may therefore be unable to globally control costs for the patient's care.

*Scoring and Analysis*

**CMS should examine whether specialty comparison pools or adjustments are appropriate for use under these measures, similar to how the Total Per Capita Costs measure is adjusted by specialty**. Certain measures, such as the ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) may be attributed to hospitalists only when a patient is more medically complex and therefore expensive. A patient who is post-STEMI with PCI and is moved out of the cardiac Intensive Care Unit (ICU) onto the general medicine floor would almost always incur more services and costs than the patient who is discharged straight from the ICU. Therefore, when hospitalists are attributed cases, it would only be for patients who are sicker and require more resources.

*Performance Period*

CMS seeks feedback on whether they should expand the performance period of the episode-based cost measures from one to two calendar years. **We are opposed to this change as it would lead to a disjointed performance period between the MIPS categories**. This would be exacerbated by the fluid nature of hospitalist practices, with providers frequently changing employers and/or practice models. We are also concerned that a two-year performance period will mask improvements in performance from year-to-year. For example, if a practice has a poor score in 2019 and improves its score during the

following year, 2020, it will take until payment year 2023 before the first year's poor performance is not included in the final score. In essence, a two-year performance period counts yearly performance in two payment years. We note that CMS is considering this methodology because many providers have too few cases attributable for the measure. If this is a widespread problem, the narrowness of the measures may need to be reconsidered.

We offer the following comments on the specific acute inpatient medical condition episode-based cost measures:

- Simple Pneumonia with Hospitalization Measure – We believe that the language surrounding the exclusions described in both the pre-trigger 120-day and the post-episode 30-day periods should be clarified. In particular, "if the patient is on hospice during this period" should be added to the exclusions for the pre-trigger, along with clarifications around if the patient already qualifies for another episode (i.e. hip arthroplasty, sepsis due to non-PNA event, heart failure), stating that this should not start a new Simple Pneumonia episode. Regarding the post episode 30-day period, patients who choose hospice in the post-hospitalization period should also be excluded. CMS must also ensure that post-discharge events that are not related to the initial pneumonia hospitalization, including falls, trauma, new infections, heart failure, etc., are explicitly excluded.

- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) – Based on the attribution methodology, some hospitalists may be attributed cases under this measure which will likely include many patients who are more medically complex and require post-ICU care on a general medicine floor. This could lead to these hospitalists appearing as higher cost when compared to providers who have cases that can be discharged out of the hospital from the cardiac ICU. We recommend CMS explore and, if appropriate, implement a specialty adjustment or comparison pool.

## Facility-Based Scoring Option

CMS is proposing to implement the Facility-Based Measures Scoring option for the 2019 performance/2021 payment years in the Merit-based Incentive Payment System (MIPS). We thank CMS for working in a collaborative manner to develop the facility-based scoring methodology and encourage CMS to proceed with its implementation. Due to their facility-based practice, hospitalists face structural challenges in both the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) pathways of the Quality Payment Program (QPP). Facility-based scoring will now provide hospitalists with a QPP participation option that more meaningfully aligns with their practice. This option represents a significant philosophical shift within quality measurement to focus more on shared accountability. **We are fully supportive of finalizing these proposals**.

**We strongly support CMS' proposed expansion of the eligibility for facility-based scoring to include Place of Service 22, Hospital Outpatient**. Place of Service 22 includes observation care, which is a significant part of the work of many hospitalists. We believe the proposed check of a single code billed under Place of Service 21 or 23 is an extremely reasonable way of ensuring that providers are truly facility-based and not simply practicing in hospital outpatient office settings. We also support this proposal.

CMS is proposing to attribute individuals to the hospital at which they provide services to the most Medicare patients. Groups are attributed to the single hospital at which a plurality of its facility-based clinicians are attributed. **We agree with CMS' approach to individual attribution and think that it simply reflects the relationship individual clinicians have with their institution. However, we strongly encourage CMS to develop a group level attribution methodology that accounts for groups that practice in multiple sites**. It is common for TINs in hospital medicine groups to have providers practicing in multiple hospitals, meaning a single attribution would ignore the work in these other sites. We believe an accountability model that accounts for multiple sites for groups will be more meaningful and actionable for these groups and ensure buy-in for providers across all the sites. To achieve an accurate and more equitable level of group attribution, groups could be given a weighted score based on attribution to multiple sites using some threshold of patients or claims to attribute several facilities. This threshold would not only ensure groups are practicing significantly in the facilities where they are being attributed but will also create a more meaningful score reflecting a wider breadth of the group's practice. Alternatively, CMS could assign a score to the group by averaging the scores attributed to individual clinicians within the group. The feedback report to the group would contain a breakdown of the score, but the group overall and all its clinicians would receive a single averaged score.

CMS proposes to automatically apply the facility-based scoring option for individuals and groups that are eligible. If an eligible individual or group also chooses to report under the MIPS normally, CMS would take the higher score. We concur that this methodology would be the least burdensome for providers and groups and stands to further encourage widespread alignment of providers with their facilities. **We have been consistently supportive of this method of automatic calculation and urge CMS to finalize this proposal.**

In terms of scoring, CMS is proposing to give the score in the Quality and Cost categories that lines up with the same percentile of the attributed facility's Hospital Value Based Purchasing (HVBP) score. **We agree that this is a fair methodology for those providers who qualify for Facility Based Scoring. However, we urge CMS to take the direct relationship that will be established between HVBP and the QPP into account when they are proposing changes to the HVBP program**. This should include consideration for the impact of adding and/or removing HVBP measures will have on providers who will be more directly accountable to the HVBP program.

We also support CMS exploring facility-based scoring in other settings, such as skilled nursing facilities.

## Alternative Payment Models (APM): Threshold Determination

SHM fully supports CMS' intention to move away from the fee-for-service payment in healthcare and incentivize the adoption of alternative payment models (APMs). However, SHM remains concerned that this intent will not be fully realized as many providers will remain unable to access the QPP incentive for Advanced APM participation given the lack of available Advanced APMs and the increasingly out-of-reach thresholds associated with qualifying for the incentive. Although CMS is proposing to include the All-Payer Combination as an option for 2019 reporting, the addition of this option will not alleviate the structural issues that providers face in meeting the thresholds. Hospitalists will not be able to meet patient or payment thresholds for either the Medicare or the all payer combination, especially as thresholds continue to grow to 75% over time. We urge the Center for Medicare and Medicaid Innovation (CMMI) to use its statutory waiver authority to its fullest extent to make the APM incentive

pathway more accessible for providers and encourage greater movement away from fee-for-service Medicare. We also note that there may be other statutory changes necessary to meet this goal and urge CMS to begin working now with Congress and other stakeholders to address any statutory changes that may be needed.

## Conclusion

SHM appreciates that CMS has spent a significant amount of time working with providers to develop policies for the third year of the Quality Payment Program and, in particular, the time spent working with SHM on facility-based scoring. We encourage CMS to continue this high level of engagement in future years. We stand ready to work with CMS on implementing future policies and continuing to improve the nation's healthcare system overall. If you have any questions or need more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Nasim Afsar, MD, MBA, SFHM
President, Society of Hospital Medicine