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January 15, 2010

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
H-232 Capitol Building
Washington, DC 20515

The Honorable Harry Reid
Majority Leader
United States Senate
S-221 U.S. Capitol Building
Washington, DC 20510

Dear Speaker Pelosi and Majority Leader Reid:

The Society of Hospital Medicine (SHM) commends you on your efforts and commitment to enact comprehensive health care reform legislation. We are the premier voice for America's 30,000 hospitalists—physicians whose primary professional focus is the general medical care and management of hospitalized patients. We have appreciated the opportunity to provide our suggestions for improvements in both the House and Senate bills at each stage of the legislative process and are pleased by the progress that has been made to date to craft legislation that provides affordable, high quality health coverage to all Americans.

Both the Affordable Health Care Act (H.R. 3962) and the Patient Protection and Affordable Health Care Act (H.R. 3590) take important steps toward improving the nation's health care system while expanding coverage to millions of uninsured Americans. Both bills include provisions that reflect many of SHM's priorities for health care reform, particularly those provisions that focus on reforming the delivery system and aligning payment with quality to promote better value for patients while reducing unnecessary costs. We are also pleased that H.R. 3962 and H.R. 3590 emphasize reducing hospital readmission rates through improvements in the discharge process and recognize the urgent need to adopt policies designed to increase the number of physicians in primary care.

As you work to reconcile the House and Senate bills, we urge you to assemble the strongest possible package to close the gaps in insurance coverage, accelerate delivery system reforms, and slow the growth in health care costs. Our specific recommendations for reconciling the two bills follow.

Hospital Value-Based Purchasing Program

SHM supports the Senate provision directing the Secretary of HHS to establish a value-based purchasing program under the hospital inpatient prospective payment system. We believe that the Medicare reimbursement system must be changed to reward value, and we strongly support policies that link quality measurement to performance-based payment. We are pleased that under the Senate bill the Secretary would establish performance standards that reward hospitals based on either attaining a certain performance standard or making improvements relative to a previous performance period. Hospitalists, as quality improvement leaders, will be critical to improving the performance of hospitals under this program.

Physicians Assistants as Attending Physicians to Serve Hospice Patients

The House bill would include physician assistants in the definition of an attending physician for purposes of a hospice written plan of care. SHM urges inclusion of this provision in the final bill. Medicare beneficiaries currently receive comparable medical care from physician assistants, and this provision would align hospice benefits with the rest of Medicare policy.

Hospital Acquired Conditions (HACs)/Infections

SHM supports efforts to reduce hospital acquired infections. We believe that the current policies in place prohibiting hospitals from increasing DRG payments for specified HACs, as well as the addition of infection rates to VBP programs, are a significant step forward in reducing infection rates.

The Senate provision to penalize hospitals in the top quartile of reported infection rates is problematic for many reasons. For example, it stands to put hospitals at "triple jeopardy" for penalties in the early phases of an important quality improvement measure. In addition, it is still difficult to discern the magnitude to which many hospital acquired infections are preventable. SHM feels it would be more reasonable to start by incentivizing hospitals which have adopted evidence-based processes of care (such as the total sterile precautions bundle described by Pronovost et al. in the Keystone ICU project to reduce catheter-related bloodstream infections [NEJM 2006; 355: 2725-32]), rather than targeting absolute thresholds for infections. Finally, using the proposed methodology of a 1% penalty to hospitals in the highest quintile of infection rates may be problematic if it is successful in achieving its stated goal. If the Senate provision succeeds in lowering HACs, the performance bar may ultimately be raised to the point that hospitals in the lowest performance quartile could still have extremely low absolute HAC event rates. To be sustainable long-term, this provision must be modified to match the payment methodology defined in the hospital VBP proposals, which also awards attainment of absolute performance targets that are independent of changes in national hospital performance.

Care Transitions

Reducing unnecessary readmissions through improvements in the hospital discharge process is a high priority for SHM. Three years ago, with a grant from The John A. Hartford Foundation, we created Project BOOST (Better Outcomes for Older adults through Safe Transitions), a comprehensive program to optimize care transitions from the hospital to home. BOOST employs strategies that have been shown to reduce avoidable readmissions, such as providing comprehensive patient risk assessment at the time of admission, improving the flow of information between sending and receiving physicians, ensuring that high risk patients receive follow-up calls within 72 hours of discharge, and improving patient and family education practices to encourage use of the teach-back process around risk specific issues. Preliminary data and qualitative analyses indicate Project BOOST is embraced by hospitals as a quality improvement project which facilitates teamwork and enhances patient satisfaction. While data is still being

collected regarding its impact on readmission rates, preliminary data from a few BOOST sites indicate there is a reduction in readmission rates.

The House bill does not include a specific transitional care program. Rather, it establishes a readmissions program that provides for funds to help hospitals with high rates of readmissions to undertake programs to reduce them. We support the provision in the House bill that would enable certain DSH hospitals to be eligible for financial assistance for transitional care activities designed to address patient noncompliance. These activities would include providing care coordination services to assist in transitions from the targeted hospital to other settings, ensuring that individuals receive a summary of care and medication orders upon discharge, and developing a quality improvement plan to assess and remedy preventable readmission rates.

Regarding the proposed study in the House bill on how the readmissions policy pertaining to hospitals could be applied to physicians, SHM believes that this provision should be modified to recognize the important care coordination role that physicians such as hospitalists play in the admission and discharge process. We recommend that an additional bullet be added in this section that would direct the Secretary to consider creating a new code for physician inpatient services related to improving care transitions/reducing readmission rates, as follows: In conducting the study, the Secretary shall consider approaches such as---“creating a new code (or codes) and payment amount (or amounts) under the fee schedule in section 1848 of the Social Security Act (in a budget neutral manner) for services provided through the discharge process such as (1) enhanced education provided to the patient and family prior to discharge, which reinforces the discharge plan and schedules a follow-up appointment; (2) post-discharge communication to review and ensure compliance with the patient’s medications and discharge plan; and (3) identification of high risk patients for whom targeted interventions may reduce hospital readmission.”

We prefer the Senate's transitional care provision as it has a specific transitional care program that would presumably contemplate activities such as those provided via Project BOOST. Under the Community-Based Care Transitions program in H.R. 3590, the Secretary would fund eligible hospitals and community-based organizations to provide transition services to certain Medicare beneficiaries at risk of re-hospitalization or a substandard transition into post-hospitalization care. Eligible hospitals would be those identified by the Secretary as having high readmission rates, such as above the 75th percentile for selected conditions. The Secretary would give priority for participation in the Community-Based Care Transitions Program to eligible community-based organizations and hospitals (that partner with community-based organizations) that provide services to medically underserved populations, small communities and rural areas. Applications by community-based organizations and hospitals to participate in this program would be required to propose at least one care transition intervention.

Accountable Care Organizations

ACOs offer an opportunity to improve integration of inpatient and outpatient care and promote joint accountability for care delivery. SHM favors allowing a variety of groups of providers, including both physicians and hospitals, to participate in ACO pilots, consistent with the Senate provision. Through pilot tests, policymakers will be able to draw from the experience of successful models to determine which work best.

Center for Medicare and Medicaid Innovation

Both bills would create a Center within CMS to test new payment methodologies aimed at improving quality and reducing costs. SHM favors the establishment of this new Center, which will improve the agency's ability to more quickly develop efficient payment models and expand them nationwide. However, we believe that both frontline clinician and researcher feedback is essential to optimize its effectiveness. Therefore, SHM recommends the following be added to Sec. 3021of

the Senate bill: "The Center shall establish a Federal Advisory Committee with representation from both practicing clinicians and health services researchers. The Advisory Committee will serve to help guide the Center, make recommendations regarding priorities, and provide input on how programs will impact practicing clinicians."

National Pilot Program on Payment Bundling

SHM believes that bundled payments have the potential to align incentives across healthcare silos and improve care coordination for Medicare beneficiaries. We strongly believe that bundling methodologies should be tested in *voluntary* pilot projects before national implementation, and we are pleased that both bills take this approach. Currently CMS has just one active bundling demonstration, the Medicare Acute Care Episode (ACE) Demonstration, involving bundled payments for hospital and physician services for a limited set of surgical episodes of care. Even if this demonstration is successful, it is by no means certain that the methodology will be applicable or appropriate in other settings, such as the management of medical patients with chronic conditions.

We strongly believe that bundled payments must be tested with a variety of diagnoses and in a variety of settings before the concept is either mandated or broadly applied. Furthermore, SHM believes that it is important for Congress to ensure that stakeholders have significant opportunity for input in all phases of the pilot program, including its design, implementation, and evaluation. Hospitalists account for approximately half of all inpatient general medical services delivered to Medicare patients and should be integrally involved in developing and implementing pilot projects involving hospitals and physicians.

Modifications to the Physician Quality Reporting Initiative

SHM supports the improvements to the physician quality reporting initiative (PQRI) program contained in both bills that provide for timely feedback to providers on their performance and an informal appeals process for providers who participated in the program but did not qualify for incentive payments. We believe that physicians should receive appropriate financial incentives for reporting on evidence-based performance measures, and we are pleased that both H.R. 3962 and H.R. 3590 extend bonus payments for participation in the PQRI. We urge Congress to keep the bonuses at the current level of 2 percent, as the House bill does. SHM also supports the 0.5 percent additional bonus for eligible professionals' submission of physician quality reporting initiative (PQRI) data through a Maintenance of Certification Program (MoC) included under Sec. 3002 in the Senate bill.

Unlike the House bill, the Senate bill would impose penalties on those physicians who do not report data under the PQRI or are unable to successfully report, beginning in 2015. We oppose penalizing physicians for failure to participate in the PQRI until the administrative difficulties that remain with reporting are improved, the significant costs of reporting for small practices are minimized, and clinically relevant measures are available for all specialties. Under the final Senate bill, payment penalties begin in 2015, an improvement over an earlier version of the bill, but still a concern.

Medicare Physician Payment Formula

SHM urges Congress to repeal the flawed Medicare Sustainable Growth Rate (SGR) and replace it with a fair, stable funding formula that keeps pace with increases in physician practice costs. A permanent solution to the flawed SGR is a critical component of health care reform, which is why we support the Medicare Physician Payment Reform Act (H.R. 3961), approved by the House of Representatives November 19. This bill would block the pending 21% cut in physician fees, eliminate all of the accumulated payment cuts, and create a new system that would provide a growth target of GDP plus two percent for evaluation and management services and preventive

services and a growth target of GDP plus one percent for all other services. We urge the Senate to join with the House of Representatives and enact this important bill into law.

Primary Care Bonus Payment

SHM urges Congress to adopt a 10 percent increase in Medicare payments for designated evaluation and management services as defined in the House bill (H.R. 3962), which includes hospital visits and other evaluation and management services in addition to office, nursing facility, domiciliary, and home visits. This would expand eligibility for the bonus payment to more primary care physicians and is an important step toward addressing the current imbalance in payment incentives that reward specialty care over primary care. SHM also recommends that the bonus payment be made permanent. We appreciate that the final Senate bill approved on December 24, 2009, removed the budget neutrality adjustment for the primary care bonus.

We also urge you to adopt the House provision to bring Medicaid reimbursement rates for primary care in line with comparable Medicare rates within four years. Failure to address reimbursement disparities will weaken an already fragile network of Medicaid providers at a time when the demand for their services will be growing.

Primary Care Workforce

SHM is very concerned about the growing shortage of primary care physicians. Any final bill must include substantive initiatives to influence more physicians to choose primary care and to sustain those currently in practice. In addition to changes in payment policies that improve payments for primary care services, we support provisions in both bills that would establish a national workforce commission to develop and coordinate workforce priorities. We appreciate that H.R. 3590 requires the Commission to analyze and make recommendations for eliminating barriers to entering and staying in careers in primary care, including physician compensation.

SHM also supports provisions in both bills that would expand scholarships and loan repayment programs for primary care physicians, including increasing funding for the National Health Services Corp, and increasing GME slots for primary care.

Health Care Quality Improvements

SHM appreciates that both bills recognized the need for strong quality improvement initiatives as part of health care reform. As a member of the Stand for Quality Coalition, we believe that the final bill must:

1. Provide for the development of national priorities and a strategy to improve care against those priorities;
2. Support the development of new quality performance measures where gaps exist to drive improved patient care;
3. Create a role for public-private partnerships to provide consultation on the use of performance measures in public reporting and payment programs;
4. Develop mechanisms to disseminate proven quality improvement systems and to train those implementing the improvements; and
5. Create nationally consistent strategies and approaches for necessary data collection, aggregation and reporting.

In particular, SHM believes it is important that the final bill retain Secs. 3501 and 3508 from the Senate bill, which require the Center for Quality Improvement and Patient Safety at AHRQ to conduct or support research and development of best practices for quality improvement, and to translate those into practice. SHM is pleased that the research conducted by the Center targets, among other things, "practical methods for reducing preventable hospital admissions and readmissions." Moreover, under this section, technical assistance grants or contracts would be

available to a variety of entities so they could implement the models and practices identified in the research conducted by the Center. This provision would provide valuable support to institutions seeking to reduce their readmission rates.

Public Reporting of Performance Information

The Senate bill (Sec. 10331) directs the Secretary of HHS to establish a Physician Compare website by 1/1/2011, which also includes other health professionals who submit data under the Medicare PQRI program. The Secretary must also implement a plan to publicly report, on that website, measures of quality and patient experience for physicians by 1/1/2013 based on data collected during 2012.

SHM is committed to improving the quality and value of health care, and supports efforts to promote greater transparency in the Medicare program by providing information on price and quality in health care to Medicare beneficiaries. As part of the FY 2009 proposed physician payment rule, CMS solicited input on the development of a Physician Compare website. SHM provided extensive feedback to the agency in its [comments](#), which reflected the unique issues for hospital medicine associated with its implementation.

We support the creation of a Physician Compare website, provided that it contains accurate and meaningful data for beneficiaries; gives physicians the opportunity to review results prior to the public release of information; and requires appropriate patient attribution and risk adjustment.

We believe the timeline outlined in the Senate bill (website developed by 1/1/11; Secretary shall implement a plan for publicly reported data available by 1/1/13 from reporting periods beginning 1/1/12) is overly ambitious, however, and should be pushed back in the legislation. It is not clear from the language what information about physician performance would be included on the website in 2011. More time is needed to ensure that the website contains meaningful, user-friendly information for beneficiaries and to allow for sufficient input from the physician community.

Moreover, physician reporting is still in the early stages of development, and many of the measures outlined in the Senate bill for potential inclusion on the website (assessment of patient outcomes, assessment of coordination of care including episodes of care and risk-adjusted resource use, assessment of efficiency, assessment of patient experience) have not been fully developed or validated. In addition, appropriate risk adjustment is critically important for measures involving an assessment of patient health outcomes and the functional status of patients. The sample sizes in any individual physician practice will likely be too small to be statistically valid. This type of data may be more appropriately reported at the level of the health plan, medical group, ACO, etc. We recommend that any efficiency measures be appropriately piloted and endorsed via groups like NQF before implementing public reporting.

Regarding the inclusion of PQRI data on a Physician Compare website, we appreciate that the issues identified by the physician community regarding the need for more timely feedback and an informal appeals process are addressed in provisions elsewhere in the House and Senate bills. It is important that these improvements be implemented and operational in the current PQRI before public reporting begins. Clinically relevant measures must also be available for all specialties.

We appreciate that the Senate bill stipulates that the Secretary would be required to include processes to assure that the data made public on Physician Compare are statistically valid and reliable, including risk adjustment mechanisms; processes to allow physicians to review their results before they are made public; processes to assure that the plan and the data on Physician Compare provide a robust and accurate portrayal of physician performance; and processes to assure accurate attribution of care when multiple providers are involved. The Senate bill specifically states that input from "multi-stakeholder groups" should be considered in selecting

quality measures. We strongly support this provision, which will be key to the success of a Physician Compare website.

Value-Based Payment Modifier

Under the Senate bill, the Secretary of Health and Human Services would be required to apply a separate, budget-neutral payment modifier to the fee-for-service physician payment formula.

The separate payment modifier would pay physicians or groups of physicians differentially based upon the relative quality of care they achieve for Medicare beneficiaries relative to cost. SHM supports the concept of applying value-based purchasing strategies to incentivize individual physicians to provide the highest quality care. However, we believe it is premature to endorse phasing in a payment system until adequate pilot testing of potential measures is underway, to ensure that the measures of quality are scientifically valid.

Extension of Gainsharing Demonstrations

SHM's favors extending the current gainsharing demonstrations authorized under the Deficit Reduction Act, as contained in both the House and Senate bills. We encourage Congress to go further in making specific changes in law that would allow hospitals and physicians to share savings resulting from efforts that improve performance and quality and reduce costs. Legal and regulatory barriers should be removed to allow greater care coordination and management of patients by both hospitals and physicians. True alignment of physician and hospital incentives cannot occur without these changes.

Rewarding Quality Through Market-based Incentives

SHM urges the incorporation of provisions from the Senate bill (Sec. 1311) that require the Secretary to develop guidelines for a payment structure that provides increased reimbursement or other incentives for improving health outcomes through, among other things, activities to reduce hospital readmissions. This provision applies to plans offered through health exchanges. A similar provision (Sec. 2717) is included in the section of the bill on private insurance market reform. Throughout the health reform debate, we have urged policymakers to restructure payment incentives so that hospitals and physicians are rewarded for preventing unplanned readmissions and applaud the inclusion of these provisions in the Senate bill.

Comparative Effectiveness Research

SHM strongly supports efforts to advance comparative effectiveness research as proposed in both the Senate and House health reform bills. We believe that generating better information on the clinical as well as cost effectiveness of health care treatments should be an integral component of health care reform. Expanded federal support for CER will help providers deliver the most appropriate care, thereby enabling the federal government to get greater value from the health care resources it funds. Patients would also have more information about treatment options so they can better participate in decisions about their care. SHM has not taken a position on where CER should be housed but emphasizes that the entity must be protected from political pressure, have adequate and stable funding, involve all stakeholders, use rigorous scientific standards, and operate transparently.

Provider Screening and Other Enrollment Requirements Under Medicare

SHM remains concerned with the Senate provisions to screen all providers participating in Medicare and urges that this requirement be dropped from the final bill. The House bill is preferable, as it limits screening to cases where there is a significant risk of fraudulent activity. Currently providers are allowed to back-bill for services provided up to 30 days prior to submission of a Medicare enrollment application, and we urge that this practice continue. The

Senate bill implies that a provider must already be fully enrolled (i.e., screening complete and enrollment approved) before providing or ordering billable services. If the new screening process extends the time from application submission to enrollment approval, this will create a significant hardship for practices hiring new doctors, particularly hospital-based physicians who are responsible for caring for all patients who present to the hospital regardless of insurance status.

Conclusion

SHM appreciates your efforts to provide affordable, high quality health coverage to all Americans. We look forward to continuing to work with you and your staff in crafting a final bill that further strengthens patient access to affordable, high-quality care and controls costs. If you should have any questions on our comments, please contact Laura Allendorf at 703-242-6273 or at LAllendorf@hospitalmedicine.org.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Flanders", with a long horizontal flourish extending to the right.

Scott A. Flanders, MD, FHM
President