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Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-1503-P, Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Proposed Rule, July 13, 2010 (Volume 75, Number 133)

Dear Dr. Berwick:

The Society of Hospital Medicine (SHM), representing nearly 10,000 hospitalists nationwide, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) physician fee schedule (PFS) proposed rule for calendar year (CY) 2011. Our comments focus on the following areas:

- Sustainable Growth Rate
- Physician Feedback Program and Value-based Payment Modifier
- Primary Care Incentive Payment Program (PCIP)
- Electronic Prescribing Program (eRx)
- Physician Quality Reporting Initiative (PQRI)

#### **Sustainable Growth Rate**

The proposed 6.1% reduction to the conversion factor would be in addition to the 23% reduction that will occur on December 1, 2010 if not prevented by legislation. Congress has enacted legislation repeatedly to prevent such reductions from occurring. Most recently, the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010" provided for a 2.2% update to the 2010 PFS, effective for services provided from June 2, 2010 through November 30, 2010. Unless Congress acts again this year, physician fees will be reduced by nearly 30% in 2011.

SHM strongly urges CMS to work with Congress to prevent this disastrous reduction from occurring and implement comprehensive reform of the Medicare physician payment system that would reward providers for delivering quality outcomes rather than for quantity of services provided.

# Physician Feedback Program and Value-based Payment Modifier

### **Attribution Methodologies**

In the proposed rule, CMS seeks comments on issues related to the Resource Use Measurement & Reporting (RUR) program, which it expects will inform implementation of the value-based payment modifier required under section 3007 of the Affordable Care Act. These include methodologies for attributing beneficiary costs to physicians using the following approaches: using the most appropriate and relevant peer groups for comparison and using the appropriate minimum volumes for case number and size of peer groups.

Due to the fact that hospitalists often share patient care responsibilities during an admission, it is more appropriate for hospital medicine groups to receive feedback at the group level rather than at the individual level. Although the "plurality minimum" standard seems to be the favored attribution method for Phase II reports, this method is not a good standard for hospital medicine groups because of their shared patient responsibilities and team based care model, which covers 24 hours per day. Therefore, SHM recommends continuing the use of "multiple-proportional" attribution, which more accurately reflects the way most hospital medicine groups operate.

### Benchmarking and Peer Groups

SHM supports efforts to benchmark appropriate and relevant peer groups for comparison. In achieving this goal, we recommend that hospital medicine groups be benchmarked against other hospital medicine groups, preferably in similar practice settings. This would require a unique identifier for hospital medicine physicians. Today hospitalists use of the E and M codes are lumped into the utilization of all physicians who round in the hospital regardless of the type of practice.

# **Primary Care Incentive Payment Program (PCIP)**

SHM supports providing primary care physicians with a 10% Medicare bonus payment for designated services, as a first step in addressing the payment disparities that are driving physicians away from generalist fields. We support adding hospital visits to the list of evaluation and management services eligible for the bonus payment, and will be seeking modifications to that effect in future legislation.

# **Electronic Prescribing Incentive Program (eRx)**

SHM supports the ongoing eRx program, but is concerned that hospitalists are not specifically excluded from the penalties for not e-prescribing that are scheduled to begin in 2012.

Evaluation and Management (E&M) coding for hospitalists was significantly changed by the elimination of the consultation codes beginning in 2010. For consultations on Observation patients or patients seen in the emergency department, hospitalists are now required to use Office or Other Outpatient billing codes (99201, 99202, 99203, 99204, or 99205). The list of E&M codes for hospitalists is therefore greatly expanded. Additionally, many hospitalists round on skilled nursing facilities, nursing homes and even make home visits (e.g. hospice), which further expands the selection of codes. The use of codes in the e-prescribing measure denominator has the potential to put hospitalists over the 10% threshold of

total allowed charges for services in the measure denominator and subject them to the penalty for failure to e-prescribe.

In the final physician payment rule for CY 2009 that established the e-prescribing incentive program, CMS listed several reasons why it supported limiting the 2009 e-prescribing denominator codes to the office and outpatient settings. SHM concurred with the agency's decision and rationale, which is stated below.

"First, physicians and other eligible professionals have limited ability to influence the adoption and availability of electronic prescribing systems in hospitals or other provider settings. Second, including codes for professional services in provider facility settings may negatively impact the ability of professionals who practice in office and facility settings to successfully report the electronic prescribing measure at the required 50 percent of cases. Without access to electronic prescribing for services furnished in a provider setting, the professional would be unable to report and these cases would count as not reporting if such codes were included in the measure denominator. Third, the effect of the electronic prescribing incentive payment is likely to have its greatest impact in stimulating adoption and use of electronic prescribing in the professional office and outpatient setting. While outpatient services are an imperfect marker, outpatient services are likely to represent the largest opportunity to expand electronic prescribing where prescribing is frequent and the decision to adopt electronic prescribing systems is also dependent on the choices, practices and funding by eligible professionals. Fourth, the statutory limitation that applies to eligibility for the incentive also applies to the future differential payment provisions. Extension of the denominator codes to hospital-based settings of care may cause professionals who exclusively practice in such settings to be liable for a differential payment for services furnished in a setting where they have limited ability to influence the adoption of electronic prescribing." 73 Fed. Reg. 69849 (November 19, 2008)

As such, hospitalists have not previously been subject to the penalty for failing to e-prescribe that will be imposed in 2012, nor have we been eligible for the bonus payment. However, due to the recent consultative coding changes and the potential that many hospitalists could now exceed the 10% threshold, SHM is requesting that CMS specifically include a hospital based EP exclusion for e-prescribing in the final rule. SHM suggests three ways this exemption could be achieved:

- 1. By including a specific exemption for hospitalists in the criteria to determine applicability.
- 2. By including hospital based EPs within the hardship exemptions. This exemption would come into play if the office or outpatient visit codes mentioned above are used with a place of service equal to "Hospital".
- 3. A final option would be to exclude hospital based EPs as a whole from the e-prescribing program. This option is sensible in that it would align the e-prescribing incentive with the Electronic Health Record Incentive Program. Such an exclusion would define an EP as being hospital-based and therefore excluded from both the incentive and penalty, regardless of the type of service provided, if more than 90% of their services are identified as being provided in such places of service as an Inpatient Hospital.

### **Physician Quality Reporting Initiative (PQRI)**

The current statute authorizes incentives for successful PQRI participation through 2014 with a bonus of 1% of total allowed Medicare charges for 2011 and then 0.5% for years 2012 to 2014. The statute will require a penalty for PQRI non participation beginning in 2015 without specifying a potential bonus for that year and beyond. In effect, this would turn the PQRI in to a strictly negative incentive program for those who do not successfully report.

SHM has heard from our membership that the expense of developing a reporting infrastructure with either claims-based reporting or through a CMS-qualified registry is significant. The potential bonus of 2% in 2009 and 2010 may not offset the expense of PQRI reporting and will be further compromised with the decreased bonus beginning 2011 to 2014. We are opposed to the use of penalties under the PQRI program and believe participation should remain voluntary. The PQRI has not yet been shown to improve patient outcomes and therefore does not warrant penalties for nonparticipating EPs.

#### The PQRI and MOC

The ACA provides that for years 2011 through 2014, the applicable bonus percent under the PQRI will be increased by 0.5 percentage points if the EP also meets certain requirements that include satisfactorily reporting data on quality measures for a year and having these results submitted on their behalf through a Maintenance of Certification Program (MOCP).

SHM supports the recognition and reward to EPs participating in MOC programs and sees this as positive incentive to our membership; although we feel the rule should clearly state that physicians who are not participating in the ABMS MOC are not eligible for the 0.5% remuneration via the MOC pathway.

We also suggest the more frequent requirement be based on standards that apply to all 24 of the ABMS Member boards, which is based on the March 2009 ABMS Board approved MOC Standards. Under these standards, more frequently would mean that a Part IV activity must be completed every 1-4 years, by physicians who voluntarily decide to participate in the MOC PQRI pathway. We believe that diplomats should not be expected to participate more frequently than once a year in a process of collecting and reporting performance data and then acting on those results by implementing a quality improvement intervention and re-measuring to understand the effect of this intervention.

# Public Reporting and Physician Compare Website

SHM supports transparency towards the goal of improving the quality of patient care and quality of service through public reporting of results. Our members are often directly involved and responsible for the hospital-level results of the Reporting Hospital Quality Data for Annual Payment Update (RHDQAPU) performance measures that are publicly reported on the Hospital Compare Website.

SHM appreciates the invitation for comment on the development of the Physician Compare website. We support the goal of the ACA to develop a Physician Compare Website and publicly report the names of EPs who participate in the PQRI or in MOC Programs, but feel that most hospitalists will not be fully able to participate until the availability of more relevant, transitions of care measures. These would be appropriate measures to recognize physicians who are committed to improving quality and performance.

At this current stage of physician-level pay for reporting, we feel that it is premature to publicly report individual-level data or the specific results of PQRI measures and agree with CMS's decision not to publicly report individual or group performance data at this time. Successful reporting of the mostly process measures that comprise the PQRI would not be a valid surrogate for patients to evaluate the actual quality of care or quality of service provided by an individual practitioner. Furthermore, consumers already face a challenge when attempting to evaluate providers. It will be even more confusing for them to understand the difference between claims-based or registry reporting and which is more accurate or reflects actual quality of care.

### **PQRI Reporting Options**

SHM has encouraged our members to participate in the PQRI since the program's inception in July 2007. We are pleased with the ongoing development of alternative reporting options including the continued use of claims-based reporting, registries and EHR reporting. While the development of reporting alternatives is a positive, SHM recommends that CMS retain claims-based reporting as an option. Claims-based reporting may be a more accurate method of reporting overall and it would be unduly burdensome and costly to force practitioners into changing their established reporting methods.

Many of our members are physicians employed by large healthcare organizations such as hospitals or academic medical centers. The infrastructure to implement PQRI reporting is expensive and this cost not being offset by a potential bonus may be an obstacle to claims-based, registry or EHR reporting.

Hospitalists have become the champions for hospital-level quality and patient safety initiatives. Accurate clinical data registries have a reporting advantage of allowing the collection of more detailed data including outcomes to provide the feedback necessary for quality improvement that can be used to improve system-level performance. SHM requests that CMS continue to evaluate the cost of PQRI reporting and the potential return on investment through improved patient outcomes or the incentive bonus to providers.

SHM is also concerned about the discrepancy between claims-based reporting and registry reporting and the question of accuracy. PQRI analysis for 2007 and 2008 showed that providers who did registry reporting had a 90% success rate for earning a PQRI bonus and claims-based reporting had a 50% success rate. Due to this large discrepancy, it will be very important to know which reporting method results in actual performance improvement based on patient outcomes and whether methods are subject to manipulation. We encourage CMS to ensure the processes and resulting data of the reporting methods are reliable and not susceptible to manipulation. This question of accuracy will need to be answered before public reporting can become a useful reality.

# **PQRI** Reporting Thresholds

SHM supports the proposal in the 2011 PQRI to reduce the reporting sample threshold for claims-based submission from 80% to 50%. We share your belief that this will increase the number of providers who will participate in the program and qualify for the PQRI bonus without unintended consequences.

# **PQRI Measures Groups**

SHM strongly supports the proposed PQRI measures group reporting option for claims-based and registry reporting. For hospitalists, the claims-based reporting of least 1 measures group for

at least 50% of patients to whom the measures group applies or the registry reporting of at least 1 measures group for at least 80% of patients to whom the measures group applies during the reporting period, offer options that are in harmony with the workflow of a hospital-based practice.

# **PQRI Group Practice Reporting Options**

SHM strongly supports the proposed 2011 definition of a group practice as 2 or more individual EPs who have reassigned their billing rights to the appropriate TIN. We appreciate that our feedback on this issue that was given during the February 2010 Listening Session was received and is being proposed for implementation.

Hospitalists practice as part of a multi-disciplinary team to optimize the care of complex hospitalized patients. The expanded group practice option supports this structure and its potential to improve patient care. We further support Group Practice Reporting Option II including the pilot program of self nomination and the requirement to successfully report a measure group along with 3 individual relevant performance measures.

# **PQRI Performance Measures Specific Issues**

SHM appreciates the invitation to comment on the implication of including or excluding any given performance measures for the proposed 2011 PQRI quality measure set, as well as providing feedback relative to your proposed approach in selecting performance measures.

Our membership has experienced a setback in successful PQRI participation for 2010 due to a measure specification change that may have inadvertently resulted in unintended consequences.

Our concerns involve the following 2010 PQRI measures:

**#32** Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy

**#33** Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge.

#36 Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services

For 2010, the denominator specifications for these measures were changed from the specifications of 2009, 2008 and 2007. The 2010 changes included the addition to the measure denominators of Evaluation and Management Codes 99221, 99222 and 9923 for Initial Hospital Care. These codes were previously not part of the measure denominators for these important stroke measures that have been reported by hospitalists since the inception of the PQRI program in July 2007. Including hospital admission codes for performance measures that are implemented on hospital discharge has proven to be problematic for hospitalist physicians attempting to successfully report these measures. It often occurs that the hospitalist discharging a patient from the hospital is not the same as the hospitalist who admitted the patient. The 2010 measure specification changes inadvertently require that the admission hospitalist also be responsible for a discharge process. This has resulted in unsuccessful reporting of these important measures by our SHM members and may prevent earning a reporting bonus with the 2010 PQRI.

We believe that adding the 99221, 99222 and 99223 codes to these measures was an oversight that resulted from the decision in 2010 to eliminate the Evaluation and Management Consultative Codes

99251, 99252, 99254 and 99255 that had previously been part of the measure denominator of these three measures when they were initially developed and included in the PQRI from 2007 to 2009.

We request that the 99221, 99222 and 99223 codes be removed from the denominators of measures #32, #33 and #36 for 2011. We further request that when the performance reporting analysis of these measures occurs in the evaluation for the 2010 PQRI bonus, that an exemption be given to EPs who may be penalized for not reaching an 80% threshold on these three measures because of the unintended effect of substituting the 99221, 99222 and 99223 series codes for the consultation 99251- 99255 series that had been eliminated from the Medicare program.

The following measures have also been part of the PQRI program since July 2007:

#56 Community-Acquired Pneumonia (CAP): VitalSigns,

#57 Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation,

#58 Community-Acquired Pneumonia (CAP): Assessment of Mental Status,

#59 Community-Acquired Pneumonia (CAP): Empiric Antibiotic

The denominator specifications of these measures limits their reporting to emergency departments and the outpatient setting. Community acquired pneumonia is a common inpatient diagnosis for Medicare beneficiaries and hospitalists are often the admitting and attending physicians for these patients. At the February 2010 Listening Session, SHM advocated to have the Initial Hospital Admit Evaluation and Management codes 99221, 99222 and 99223 added to the measure denominators to allow reporting by hospitalists in the inpatient setting. Several of these pneumonia measures are also part of the hospital-level RHQDAPU program and by having an expanded application for reporting of these measures in the inpatient setting there would be an opportunity for harmonizing hospital-level and physician-level performance measurement and reporting. SHM also recognizes that it is appropriate to have combined these measures into the Community Acquired Pneumonia Measures Group.

# **PQRI Proposed Performance Measures for 2011**

SHM is very pleased with the proposed inclusion in the 2011 PQRI of the transitions of care performance measures as shown in table 54 on page 536 of the proposed rule:

- Care Transitions: Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care):
- Care Transitions: Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care):
- Care Transitions: Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care):
- Care Transitions: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

These measures were developed by the AMA Physician's Consortium for Performance Improvement with the specific intent to improve the care of Medicare beneficiaries at the vulnerable time of transitions into and out of the hospital. These measures are based on evidence-based processes that have been shown to reduce readmissions, limit medication errors and improve the patient perspective of their care.

SHM recognizes the potential difficulty with attribution for these measures and the need to develop reporting specifications for quality improvement and accountability. We propose that these measures are ready for individual or group-level attribution and can be reported through claims, a registry and EHR performance measurement platforms. SHM offers to facilitate the implementation of these measures and again commends CMS for proposing to include them in the 2011 PQRI.

SHM supports the proposed inclusion in the 2011 PQRI of the Heart Failure Measures Group. Heart failure is another common inpatient diagnosis that results in substantial morbidity and mortality for Medicare beneficiaries. Hospitalists are the admitting, attending or consulting physician on an increasing number of patients hospitalized with heart failure. Performance improvement for this population could have a significant impact on the efficiency of the Medicare program.

SHM also appreciates the receptivity to our comments at the February 2010 Listening Session about developing a Community Acquired Pneumonia Measures Group and its proposed inclusion in the 2011 PQRI. Performance measures for pneumonia are already an important part of the RHQDAPU program. Hospitalists are increasingly becoming the champions for the hospital-level performance agenda through the RHQDAPU measures. SHM sees the inclusion of the pneumonia and heart failure measures groups in the 2011 PQRI as an opportunity for hospital-level and physician-level alignment with a performance agenda that will result in improved quality of care and quality of service for Medicare beneficiaries.

SHM appreciates the opportunity to provide comments on the 2011 physician payment proposed rule. If we may provide any additional information, please contact Joshua Boswell, Health Policy Analyst, at JBoswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Jeffrey Wiese, MD, SFHM

President