Society of Hospital Medicine
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Society of Hospital Medicine Response to Medicare Request for Information "Unleashing Prosperity Through Deregulation of the Medicare Program"

SHM submitted the following comments to a deregulatory Request for Information (RFI) for the Medicare program. The comments build on policy issues and priorities for hospitalists identified through SHM's recent advocacy efforts. Comments were submitted on June 10, 2025 through the Medicare Regulatory Relief webform.

Topic 1: Streamline Regulatory Requirements

Eliminate the Skilled Nursing Facility Three-Day Stay Rule

Eliminate the skilled nursing facility three-day length of stay requirement that often delays patients from transitioning to the most appropriate site of care. Since Medicare coverage for SNF care is dependent on inpatient stays, patients discharged from observation to SNFs are faced with the decision to pay high, often unexpected bills for their SNF stays or forego necessary follow-up SNF care. The Office of Inspector General (OIG) has recognized the 3-day stay rule creates inconsistencies in coverage for Medicare beneficiaries and regularly cites changing this policy as one of its Top 25 Unimplemented Recommendations. (*Office of Inspector General. 2021. OIG's top unimplemented recommendations: Solutions to reduce fraud, waste, and abuse in HHS programs. U.S. Department of Health and Human Services: Office of Inspector General.* *https://oig.hhs.gov/documents/top-unimplemented-recommendations/1097/compendium2021.pdf*)

Additionally, the three-day stay requirement for SNF coverage was waived during the COVID-19 Public Health Emergency (PHE). Data from this period showed that expanding access to SNF coverage did not dramatically increase spending or utilization. (https://avalere.com/insights/snf-3-day-waiver-use-at-the-end-of-the-covid-19-public-health-emergency). We believe this policy can be responsibly reformed while still protecting the integrity of the Medicare Trust Funds.

Eliminate the CAH 96-Hour Rule

Eliminate the CAH 96-hour rule as a condition of participation (CoP) requirement that physicians who work in Critical Access Hospitals (CAHs) certify, with reasonable certainty, that an individual patient should expect to be discharged or admitted to another hospital within 96 hours. Requiring clinicians to certify each individual patient will have a length of stay (LOS) of fewer than 96 hours creates a significant administrative burden. It is unrealistic to expect providers to predict a patient's LOS with such a high degree of accuracy. CAHs must meet an annual patient LOS average of 96 hours or less, meaning hospitals already track this data at the institutional level. Therefore, requiring individual clinicians to certify each patient's LOS creates duplicative and unnecessary administrative work. In many cases, it also creates inappropriate pressure to transfer patients to other sites. Community hospitals and tertiary care centers are often at capacity. Transferring CAH patients to these sites, many of which are far from patients' home communities, is a poor use of resources. It further strains hospital capacity, contributing to boarding severely ill patients in emergency departments. As rural health care access, which is already limited, continues to contract due to facility closures, staffing shortages, and scarce resources, the 96-hour physician certification rule redirects already limited resources away from bedside care.

Eliminate the Special Privacy Protections for Behavior Health Patients under 42 CFR Part 2

42 CFR Part 2 outlines special confidentiality protections for patients with substance use disorders. In practice, these protections have become barriers to ensure patients are receiving coordinated care across

settings and providers. We strongly urge the agency to waive or otherwise eliminate these special protections to ensure healthcare providers are able to share information with each other to get patients the care they need.

Medicare Advantage Plans: Standardize Rules and Requirements to Minimize Burden and Establish Consistency

Medicare Advantage (MA) Plans are designed to provide seniors with health insurance options to fit their lifestyle and coverage needs. However, the lack of standardized rules and coverage within the various MA plans creates significant burden and confusion for providers. Additionally, the lack of standardization creates unnecessary, and sometimes dangerous, delays to patient care.

For example, skilled nursing facility (SNF) admission requirements demonstrate these inconsistencies. To qualify for SNF coverage, some MA plans require patients to receive both physical and occupational therapy, while other plans only require one service. Other plans may require a physician-to-physician phone call for justification for post-acute placement. The resulting confusion about what each of the many plans require can result in transfers back to the sending facility or delaying transfers until requirements are met. Additionally, MA plans often require prior authorization for many health care services, which can lead to lengthy and potentially dangerous delays in care.

Providers and case managers are forced to navigate these inconsistent and often burdensome coverage requirements. We believe CMS should standardize MA plan requirements and govern the appeals process. This will reduce burden while improving patient care and satisfaction.

Topic 2: Opportunities to Reduce Burden of Reporting and Documentation

Review the Necessity and Benefit of Documentation Requirements – Eliminate or Streamline where possible.

Much of the administrative burden in the healthcare system stems from documentation requirements to control coverage and reimbursement. Many of these documentation requirements were developed prior to the widespread implementation of EHR systems and have not been updated to address changing trends in healthcare. Many face to face forms, such as those for home health services, physician certification on home health paperwork, physician countersignatures for documentation by advance practice providers (APPs), yearly refreshing of HCC diagnoses for chronic diseases or permanent conditions, and forms associated with home oxygen, durable medical equipment, requirements for outpatient physical therapy plans of care to be signed off by a physician or nurse practitioner every 90 days, and ambulance transport, for example, are demonstrative of paperwork that take away from clinical time without providing clear benefit. While each form in isolation may be relatively low burden, there are currently so many mandated forms and processes that more time is spent on navigating and completing requisite forms than on caring for patients. We recommend CMS undertake a systematic review of forms and certifications required for coverage and reimbursement. This review should focus on streamlining documentation and using information already documented in the electronic medical record.

Part of this effort should include the streamlining of Medicare mandatory notices to patients, including eliminating, where applicable, rules that require providers to give notice both in-person and via paper notices. Examples of such notices include the Important Message from Medicare, Advance Beneficiary Notice of Non-coverage, and Medicare Outpatient Observation Notice, the Notice of Medicare Non-Coverage, and Medicare Change of Status Notice.

Reducing Burden of the Merit-based Incentive Payment System (MIPS)

The Society of Hospital Medicine (SHM) has long voiced concern over the burdens associated with compliance in the Merit-based Incentive Payment System (MIPS) and the lack of evidence for the program improving care. We urge CMS to pursue simplification or elimination of the MIPS in its current form, focusing on reducing administrative burdens associated with the program. In the absence of elimination, we offer the suggestions below for streamlining the program:

- **Eliminate MIPS Value Pathways from the Merit-based Incentive Payment System (MIPS) and keep subgroup reporting voluntary.** This reporting pathway has been developed by CMS in the past few years to reframe the MIPS requirements, and CMS has indicated its intention to make it required for MIPS participation as early as 2029. MVPs have not improved upon issues in the MIPS program and are not available or feasible for all specialties. The addition of MVPs adds new complications to participation in the MIPS and will add significant burden to reporting.
- **Eliminate MIPS scoring provisions that penalize providers for having too few measures or measures that are topped out**. A lack of available or competitive measures should not lead to disadvantage in the program. For topped out measures, minute differences in performance lead to wildly different scores – yet these are not meaningful distinctions in patient care.
- **Revisit Cost Category measures as these continue to have significant attribution issues**. Especially in hospital medicine where patient care is team-based and hand-offs are common, attributing measures to the care provided by a single provider is not possible. Yet, the MIPS cost measures are, by and large, structured to be attributable to a single provider.

Refine or Eliminate Measures in CMS' Hospital Programs

CMS manages a wide inventory of measures for multiple hospital-level programs. While these measures are often targeted in priority clinical areas, experience with numerous measures leads SHM to recommend CMS make significant changes to the measures or the inventories of programs to simplify and streamline the reporting programs.

- **Replace the sepsis bundle measure, as required at 79 FR 50241 and 88 FR 59801, with a measure of sepsis outcomes.** Hospitals have spent considerable effort — and achieved significant results — in mitigating the incidence and severity of sepsis, saving lives in the process. Unfortunately, research has demonstrated that the sepsis bundle measure has not led to better outcomes yet entails an enormous administrative burden. As a process measure, it is overly prescriptive about the management of sepsis, while lagging behind clinical advances in sepsis treatment. We encourage the administration to work with hospitals on developing a sepsis outcome measure that will help them further advance the fight against sepsis, while reducing unnecessary burdens in the system.
- **Refine or eliminate Hospital Harm Falls with Injury Measure.** SHM opposes the adoption of the Hospital Harm Falls with Injury Measure due to unintended consequences of over-labeling of patients as fall risks and the downstream impact this can have on patient rehabilitation or recovery. We also noted that there is limited evidence for what works in falls prevention.
- **Stop using 30-Day Readmissions Measures and consider eliminating the Readmissions Reduction Program**. Under the Hospital Readmissions Reduction Program (HRRP), CMS has made prevention of readmissions a major priority for hospitals. These measures all have 30-day

readmission windows, despite research suggesting that the work and effort of hospitals may only really impact readmissions within seven to ten days post discharge. SHM continues to oppose the use of 30-day readmission measures, and urges the agency to focus instead on what is within a hospital's locus of control. CMS should also consider eliminating the HRRP entirely as it is topped out, and not providing meaningful or actionable information. We encourage the agency to completely rethink its approach to focus on preventable readmissions.

- **Eliminate (or, at a minimum, significantly streamline) the onerous Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey of hospitals**, as the quality of the survey instrument and use of the results have degraded due to low response rates. Also, the HCAHPS survey continues to be inappropriately used to judge individual clinician performance and should be stopped.
- **Refine the Excess Days in Acute Care Measures.** Similar to readmissions measures, the excess days in acute care measures, including measures for pneumonia, heart failure, and acute myocardial infarction, have 30-day windows. We urge the agency to shorten the timeframe for these measures to focus on what is actionable and reflective of the work of hospitals and hospital-based clinicians.