shm
Society of Hospital Medicine

Empowering hospitalists.
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August 1, 2018

The Honorable Mike Kelly
U.S. House of Representatives
1707 Longworth House Office Bldg.
Washington, DC 20515

The Honorable Ron Kind
U.S. House of Representatives
1502 Longworth House Office Bldg.
Washington, DC 20515

The Honorable Markwayne Mullin
U.S. House of Representatives
1113 Longworth House Office Bldg.
Washington, DC 20515

The Honorable Ami Bera, M.D.
U.S. House of Representatives
1431 Longworth House Office Bldg.
Washington, DC 20515

Dear Members of the House Health Care Innovation Caucus,

The Society of Hospital Medicine (SHM), representing the nation's hospitalists, applauds you for forming the bipartisan House Health Care Innovation Caucus. We share your enthusiasm for seeking out novel approaches to the myriad problems facing the healthcare system.

Hospitalists are front-line clinicians in America's acute care hospitals whose professional focus is the general medical care of hospitalized patients. Their unique position in the healthcare system affords hospitalists a distinct perspective and systems-based approach to confronting and solving challenges at the individual provider and overall institutional level of the hospital. In this capacity, hospitalists not only manage the inpatient clinical care of their patients, but also work to enhance the performance of their hospitals and health systems. They provide care for millions of patients each year, including a large majority of hospitalized Medicare beneficiaries, and are national leaders in quality improvement, resource stewardship and care coordination.

Since the inception of the specialty of hospital medicine and the founding of SHM in the 1990's, hospitalists have been at the forefront of delivery and payment system reform and are integral leaders in helping the healthcare system move from volume to value. Hospitalists from across the country are engaged in driving innovation aimed at achieving higher quality and lower cost care to their patients. As such, they are key leaders and partners in alternative payment model adoption, including bundled payments, the Medicare Shared Savings Program Accountable Care Organizations (ACOs), and managed care. SHM's Center for Quality Improvement has also developed programs and

initiatives that engage providers at a local level on process, systems, and institutional improvement on a range of topics that include improvements in care transitions, palliative care, treatment of venous thromboembolism, medication reconciliation, and glycemic control.

We offer the following feedback on the questions in your July 9, 2018 letter to stakeholders and stand ready to work with you on implementing these and other policy changes to help improve the safety, cost-effectiveness, and efficiency of the healthcare system.

Barriers to Innovation in Medicare and Medicaid—Payment and Reimbursement

Medicare's observation stay is a clear example of outdated policies that continue to stifle innovation and impede patient care. Since 2013, the Centers for Medicare and Medicaid Services (CMS) has required that all hospital stays of less than two midnights be billed as observation. Medicare considers observation care to be an outpatient status, despite the fact that it is provided within the hospital walls, and in many cases, is virtually indistinguishable from care provided to inpatients. The Innovation Caucus should target observation care policy as an area for significant reform to simplify billing and reimbursement policies and ensure more Medicare dollars are being spent on direct patient care and quality improvement.

Navigating the rules around inpatient admissions and outpatient observation care requires a significant shift of healthcare resources away from direct patient care. Hospitalists report that, in addition to themselves as the direct healthcare provider, status determinations between inpatient admissions and outpatient observation care require the input of a myriad of staff including nursing, coding/compliance teams, utilization review, case managers and external review organizations.[1] A recent study in the *Journal of Hospital Medicine* indicated that an average of 5.1 full time employees, not including case managers, are required to navigate the audit and appeals process associated with hospital stay status determinations.[2] Another recent study in *Professional Case Management* indicated "hospital case managers' time is inordinately leveraged by issues related to observation status/leveling of patients and Centers for Medicare and Medicaid Services compliance. The data also suggest that hospital case management has taken a conceptual trajectory that has deviated significantly from what was initially conceived (quality, advocacy, and care coordination) and what is publicly purported."[3] The end result for providers is that staff, time, and money are being directly pulled away from patient care and quality improvement efforts (such as novel transitions programs, communication, and coordination of care) to comply with existing Medicare policies. SHM has developed some ideas for fixing the problems with

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[1] Society of Hospital Medicine. The Hospital Observation Care Problem: Perspectives and Solutions from the Society of Hospital Medicine. September 2017. Accessed July 23, 2018 via https://www.hospitalmedicine.org/globalassets/policy-and-advocacy/advocacy-pdf/shms-observation-white-paper-2017.

[2] Sheehy AM, et al. Recovery audit contractor audits and appeals at three academic medical centers. J Hosp. Med. 2015 Apr;10(4):212-219.

[3] Reynolds, JJ. Another Look at Roles and Functions. Has Hospital Case Management Lost Its Way? Prof. Case Mgmt. 2013 Sept./Oct.; 18(5):246-254.

Observation in its white paper, The Hospital Observation Care Problem: Perspectives and Solutions from the Society of Hospital Medicine.[4]

Barriers to Innovation in Medicare and Medicaid—Policy and Regulation

The Medicare Access and CHIP Reauthorization Act (MACRA, 2015) seeks to incentivize providers to move away from fee-for-service (FFS) Medicare and towards Alternative Payment Models (APMs). It provides a 5% lump sum incentive payment through 2024 for qualified providers in APMs and establishes thresholds of payments or patients to determine qualified status. In 2019 and 2020, the thresholds are set at 25% of Medicare payments; 2021 and 2022 at 50%; and 2023 and beyond at 75%. Starting in 2021, the payment thresholds may be met through all-payer analyses. Providers may also meet a threshold of Medicare patients, which CMS has promulgated at a slightly lower rate. We understand these thresholds were designed to ensure that providers move meaningfully away from the FFS system, but these thresholds have inserted significant uncertainty for those providers who may otherwise desire to adopt alternative payment models. We recommend the Innovation Caucus prioritize finding different mechanisms to incentivize moving providers away from fee-for-service and onto alternative payment models.

SHM has serious concerns about the ability of providers to meet thresholds, particularly as they increase in future years. Moving into an APM requires significant investment from providers for appropriate infrastructure (staffing, data analytics), education, and restructuring provider workflow. Based on our member's experiences in the Bundled Payments for Care Improvement (BPCI) initiative, we believe the thresholds will lock many providers out of moving into the APM track even after making the investment and attempt. Many of the provider-led APMs tend to be disease/condition or specialty specific, meaning the covered revenue or patients are a smaller proportion of the provider's total practice. By way of example, hospitalists as a specialty are by far the largest participants in BPCI and we expect them to also be the largest participants in Advanced BPCI when the model becomes available. Despite their aggressive efforts to move away from FFS, we believe that very few hospitalists, if any, will qualify for the APM track under the current payment/patient thresholds.

Using a threshold-based criterion also renders a lack of predictability on whether a provider who is participating in an APM will be able to qualify for the MACRA APM track. To qualify for the track, a provider must meet a prescribed threshold, however, changes to their patient population could lead a participant to qualify one year and not the next. This problem becomes exacerbated as the thresholds increase by law. Uncertainty in this space impedes investment and movement away from FFS Medicare payments.

The Innovation Caucus could address this significant barrier by granting the Secretary of HHS the flexibility to determine APM participation/qualified provider status via means other than by thresholds. Alternatively, the Caucus could work to develop an additional pathway that opens up APM participation to more clinicians.

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[4] The Hospital Observation Care Problem: Perspectives and Solutions from the Society of Hospital Medicine. September 2017. Accessed July 23, 2018 via https://www.hospitalmedicine.org/globalassets/policy-and-advocacy/advocacy-pdf/shms-observation-white-paper-2017

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Developing Measures that Accurately Reflect Quality, Safety and Value

With the passage of the Affordable Care Act (2010) and the Medicare Access and CHIP Reauthorization Act (MACRA, 2015), Congress has signaled its intent to move Medicare towards a value-based payment system. This legislation created pay-for-performance programs, including Hospital Value-Based Purchasing (HVBP) and the Merit-based Incentive Payment System (MIPS), that seek to reward providers for the value of care they furnish to Medicare beneficiaries. To measure value and to underpin the payment adjustments associated with these programs, there has been a significant shift towards developing quality, cost, and resource use metrics. A majority of the measures currently in use are "process measures," although stakeholders have begun to prioritize the development of outcome measures, including patient-reported outcomes, for use in future years.

We believe there is ample opportunity for reforms to quality measurement and pay-for-performance programs. There should be an emphasis on paring down the number of reported measures to focus on high-value indicators, such as outcome measures, and on ensuring the transparency and reliability of the metrics. Quality measures in general, and outcomes in particular, are important as markers of where the healthcare system is heading and should be viewed as tools to help get us there, rather than blunt indicators of an individual provider's quality. Some changes may require retooling the measures themselves, while other changes may require reforming the underlying programs. Many outcomes, for example, will be difficult to attribute to a single provider, particularly for providers like hospitalists who practice in facilities where success is heavily dependent on multi-disciplinary teams and coordination among medical specialties. However, due to the structure of provider pay-for-performance programs that generally hold individuals accountable for their performance, the expectation is that measures used will be attributable down to the individual level. This fundamental disconnect leads to dissatisfaction and skepticism about the value of quality measures, and stifles cross-specialty and cross-disciplinary accountability in the healthcare system.

SHM commends the goals of the Caucus in developing innovative solutions to the most vexing challenges confronting the U.S. healthcare system. We look forward to future work with the Caucus as you continue to consider how to drive forward transformation in healthcare. If you have any questions or need more information, please contact Josh Boswell, Director of Government Relations at 267-702-2635 or jboswell@hospitalmedicine.org.

Sincerely,

Nasim Afsar

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President, Society of Hospital Medicine