

September 11, 2017

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
P.O. Box 8016
Baltimore, MD 21244-8013

Dear Administrator Verma,

The Society of Hospital Medicine (SHM), on behalf of the nation's nearly 57,000 hospitalists, appreciates the opportunity to provide comments on the proposed rule CMS-1676-P *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program*.

Hospitalists are experts in the primary medical care for hospitalized patients. In this role, they provide a significant amount of care to Medicare and Medicaid beneficiaries, ensuring safe and efficient delivery of care during hospital stays and transitions in and out of the hospital. The unique position of hospitalists within the healthcare system affords a distinctive role in facilitating both individual physician-level and systems/hospital-level performance agendas.

SHM offers the following comments on the proposals in the CY 2018 Physician Fee Schedule proposed rule:

Evaluation and Management (E/M) Guidelines and Care Management Services

SHM appreciates that CMS is exploring changes to Evaluation and Management (E&M) documentation requirements and agrees that significant changes are necessary. CMS cites the history and physical (H&P) requirements as potential targets for reform or elimination.

SHM strongly urges elimination of the H&P portion of documentation as part of the requirements for billing an E&M code. Hospitalists are the predominate billers of E&M codes in hospitals as part of their role in leading the inpatient medical care and observation care for patients. It is our experience that the existing documentation requirements are duplicative, are a major source of excess information in the electronic health record (EHR), and do not contribute meaningfully to patient care.

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We believe clinicians should have the discretion to include what is necessary and beneficial in their documentation. Some history should be provided in both the initial and subsequent encounters, but this can be limited to the patient's presenting complaint and any other elements relevant to their current condition or other active chronic issues. The same can be said for the physical, in that a physical exam should be documented, but the provider should be free to choose which elements to include, or not, based on the patient's current presentation. In other words, the current requirements which necessitate inclusion of a minimum number of elements, organ systems, or other criteria should be replaced with information the provider determines is pertinent and clinically meaningful.

Regarding the initial E&M encounter, the provider should be able to choose to include the past medical, family and social history, but these elements should not be mandatory. Considering the widespread adoption of EHRs (particularly in hospitals), these elements of the history are frequently already recorded from previous encounters, and are therefore readily available for review, should they be relevant to the case at hand. We note that providers are trained to know when a clinical condition warrants more in-depth history or physical. It should not be mandated that the past medical, social, or family history be included in order to meet billing criteria for a particular level of service.

If the H&P documentation requirements are eliminated, the medical decision making (MDM) would be the foremost criteria for E&M documentation. As it currently stands, the MDM portion consists of 3 categories: diagnoses, data, and risk, all of which are combined to generate a complexity score. We suggest again that the providers have broad discretion to decide what to include in this section, but think it is reasonable to document any relevant diagnoses, both acute and chronic, as well as information that would allow an appraisal of the patient's overall risk according to the current risk categories specified in the 1995 and 1997 guidelines. The total number of diagnoses listed or total amount of data reviewed should not have an impact on the level of service. For example, patients with multiple diagnoses may not require the most amount of clinical work and vice versa. The complexity score should also be simplified to better capture the meaningful differences between patients. We recommend CMS work with stakeholders to update the required documentation in the MDM to be better reflective of current practice.

The structure of hospitalist practice brings into clear relief the redundancies of the current documentation requirements. Hospitalists see patients in shifts, with hand-offs between providers from one shift to the next. The current documentation requirements encourage repetitive work and unnecessary information be capture and recaptured for each of the encounters eligible for billing. Without documentation relief, patient records become both unwieldy and duplicative, which makes it more difficult for providers to find and focus on the most important details in the record.

Simplification, clarity, and standardization to E/M documentation is needed to provide a high level of care for the patient while appropriately communicating information to other care team members. Simplification should also decrease the variation among providers for level of service billed and discourage any gaming that could occur. We strongly urge a change to the documentation requirements to allow providers to focus on providing appropriate clinical care and not on unnecessary billing criteria.

Physician Quality Reporting System (PQRS) and Value Based Payment Modifier (VM)

Under the current PQRS and VBPM programs, hospitalists have been unable to meet the required number of measures for reporting based on the lack of available and applicable measures, and

consistently receive downward payment adjustments. Although the Quality Payment Program (QPP) created a pathway for hospitalists to report 6 realistic measures and avoid being unfairly penalized, current requirements for PQRS and VBPM were not adjusted to allay these issues for hospitalists and other providers. We appreciate that CMS is willing to alter the current programs to match QPP standards for quality reporting and ensure that providers are not at a disadvantage for the remaining payment adjustment year under PQRS and VBPM.

SHM urges CMS to finalize the changes proposed to PQRS requirements for the 2018 payment adjustment to lower the minimum number of measures from 9 to 6 with no domain or cross cutting measure requirements. Hospitalists struggled to find 9 measures to report under the PQRS program, a reality that was recognized in the first-year policies for the MIPS.

Under the Physician Value-based Payment Modifier (VM), CMS has proposed to reduce the automatic downward adjustment for groups and solo practitioners who are subject to the full VM penalty. Providers who do not report any quality measures or otherwise fail PQRS reporting would face a negative two percent payment adjustment under the VM, instead of the slated four percent penalty. Smaller groups and solo practitioners would face a negative one percent penalty. We support this proposal as it brings the total potential payment adjustments closer in line with the potential MIPS payment adjustments. CMS also proposed to hold all groups and solo practitioners who successfully report quality measures harmless from downward payment adjustments under the VM quality tiering regardless of their performance. **We strongly support these proposals as relief from the current VM payment adjustments.**

MACRA Patient Relationship Categories and Codes

CMS proposes to establish a set of patient relationship codes and allow voluntary reporting of the proposed HCPCS modifiers on claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018. We believe there is significant potential for patient relationship codes to improve the attribution of patients to providers, and to improve the way clinicians are measured and assessed in pay for performance programs.

SHM is concerned that the proposed patient relationship codes could yield significant variation in how providers report these codes even when making good-faith efforts to assign the category they believe best fits their practice. Based upon our reading of the proposal and background from CMS' earlier drafts, hospitalists would use number 3x, "episodic/broad services" most frequently. At the same time, a hospitalist could reasonably use number 4x, "episodic/focused services". Confusion about the differences between "broad" and "focused" and the reality of having so many providers involved in the care of hospitalized patients will yield inconsistent responses. For example, in an identical patient set, one hospitalist may indicate all their interactions as X3; a different hospitalist, X4; and a third hospitalist, a mix of the two. We believe this raises serious questions about the utility of these codes, particularly for their expected application in resource use and episode-based measures.

Accordingly, SHM has concerns about finalizing the proposal absent clear guidelines of how these codes would be operationalized. We strongly encourage CMS to provide more information and discussion prior to finalizing the patient relationship modifiers, as it will help stakeholders evaluate the potential value of the codes and identify potential issues and solutions.

Because hospitals have an ecosystem of providers caring for patients, it can be difficult to assign patient relationships definitively and to allocate accountability for costs and resource use with consistency and accuracy. Even if, for example, it would be appropriate to assign a X3 for a given hospitalist's patient, specialty consultants often drive costs for patients by requesting tests, procedures and medications. While hospitalists may be coordinating and managing care for the patient, they may not have control over the full scope of resources expended on the patient. This could create issues for performance on certain cost metrics and even create conflict among providers. Aligned with our recommendation for CMS to provide details on the intended use of these codes, we ask CMS to explain how, for example, X3 and X4 interact, overlap and potentially conflict in the context of their use in cost metrics.

SHM also encourages CMS to clarify how these patient relationship categories and modifiers could interact with alternative payment models (APM). Given that some APM models may use different patient attribution methodologies, we advise CMS to ensure this methodology does not become a limiting factor for APM development or individualized APM attribution.

As an alternative to the proposed modifiers, we believe CMS could frame the codes around the providers, instead of the care episode. This would enable providers to more readily identify their role and increase consistency in the selection and application of the codes. Primary identifiers could include: continuing (chronic) care provider code, CCP code, acute care provider code, ACP code (hospital care), post-acute care provider care, PACP code, clinical support provider code, CSP code, followed by a secondary identifier such as how the provider views their relationship with the patient (i.e. considers themselves to have primary responsibility for the care of the patient, furnishes care and services only as ordered by another physician, etc.). These identifiers would more accurately reflect the way providers view their practices.

Although we have concerns about the proposed modifiers and categories, we do appreciate that CMS proposed to make the use of these codes voluntary at the start. It will be important for providers to have time to explore and use the codes and to adjust reporting. We urge CMS to have comprehensive education and a mechanism to provide feedback to providers in the use of these codes. We also strongly encourage CMS to remain open to changes and adjustments to these codes as needed.

Request for Information on CMS Flexibilities and Efficiencies

SHM appreciates CMS' openness to regulatory, subregulatory, policy, practice, and procedural changes aimed at improving the healthcare system. SHM agrees with the goals outlined to reduce burdens, improve quality of care, decrease costs, ensure better decision making and, most importantly, make the healthcare system more accessible and efficient. In the past, we have stated our interest in simplifying observation care, the 2-Midnight Rule, and related policies, which fit the stated goals for this RFI.

Observation care has been the subject of much scrutiny over the last decade, and SHM has been at the forefront of the deliberations. Per our analysis of 2012 Medicare physician pay data, hospitalists provide the predominant amount of observation care around the nation, billing for about 58% of all initial and observation discharge visits.¹ Hospitalists see firsthand the challenges current policies for observation

¹ Analysis by SHM using threshold methodology outlined in Lapps, J, *et al. Updating Threshold-Based Identification of Hospitalists in 2012 Medicare Pay Data*. Journal of Hospital Medicine. January 2016. 11:1: 45-47.

status pose for patients and families, and experience daily the administrative challenges and burdens associated with inpatient admission decisions.

In 2013, CMS stated its intent to simplify observation and inpatient status determinations by creating the 2-midnight rule – in the hopes that a time-based determinant would alleviate the increased use of observation care as well as decrease long observation stays. Although the 2-midnight rule had good intentions, research has shown that it has not fixed many of the core problems with observation policy, including length of observation stays and access to post-acute care services.^{2,3,4}

Observation is an administrative billing distinction that puts a major strain on the patient-physician relationship. It creates a perpetual state of frustration for providers, and the opacity of its policies confuses and harms patients. Observation patients receive identical care to that of inpatients but experience significant financial differences such as cost-sharing and coverage for post-acute SNF care. Physicians are drawn away from important clinical care concerns to administrative tasks; focusing on the timing of a patient's admission rather than their clinical needs when determining their status. In addition, the trust underlying a therapeutic patient-physician relationship is often compromised, as patients often ask their physician to change their status to inpatient to receive Part A coverage, risking Medicare fraud. Many patients, upon learning that they are under observation and its financial implications, will even forego necessary care. Unable to pay for a medically-necessary SNF stay out of pocket, patients may choose to go home, risking further complicating their health status and a return to the hospital with an unnecessary, costly, and potentially avoidable readmission.

The Medicare requirement for three midnights as an inpatient to initiate Medicare SNF coverage is a major barrier for getting patients the care they need. There has been significant movement in the Medicare Advantage program and in some Alternative Payment Models (ACOs and bundled payments) to waive this SNF coverage requirement. In fact, research looking at MA programs between 2006 to 2010 who had a waiver for this requirement saw decreases in length of stay and static rates of SNF utilization and length of stay.⁵ Indeed, current pay-for-performance measures on cost, resource use, readmissions and quality may already serve as checks on potential overutilization of post-acute services. This suggests CMS could implement broader changes to the SNF coverage requirement without significant negative impacts on the Medicare Trust Fund. **As SNF coverage is a critical point of tension for patients, we urge CMS to make changes to this aspect of the policy, alone or in conjunction with broader observation reforms.**

With the passage of the Notification of Observation Treatment and Implication for Care Eligibility (NOTICE) Act of 2015, hospitals are now required to inform observation patients of their status and its possible financial implications using the Medicare Outpatient Observation Notice (MOON) form. Although well-intentioned, NOTICE has also created unnecessary problems and confusion that impedes

² MedPAC June 2015 Report to Congress: Medicare and the Health Care Delivery System. Available at: <http://www.medpac.gov/docs/default-source/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0>. Accessed June 2, 2017.

³ MedPAC March 2017 Report to Congress: Medicare Payment Policy. Available at: http://medpac.gov/docs/default-source/reports/mar17_entirereport224610adfa9c665e80adff00009edf9c.pdf?sfvrsn=0. Accessed May 23, 2017.

⁴ OEI-02-15-00020 Office of Inspector General: Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy. Available at: <https://oig.hhs.gov/oei/reports/oei-02-15-00020.pdf>. Accessed May 23, 2017.

⁵ Grebela R, Keohane L, Lee Y, Lipsitz L, Rahman M, Trevedi A. Waiving the threeday rule: admissions and length-of-stay at hospitals and skilled nursing facilities did not increase. *Health Affairs*. 2015;34:1324-1330.

the actual delivery of care. Transparency between providers and patients is a necessary and worthwhile goal, but the MOON does nothing to address the underlying problems with the policies surrounding observation stays, and has led already to reports of damaged physician-patient relationships.

There are many nuanced issues with observation care, particularly the administrative burden it places on hospitals and hospitalists to make status determinations, effectuate and address internal reviews, and respond to Medicare contractor/auditor challenges. This burden is further multiplied by the resources needed to analyze and comply with ever changing and often unclear regulations surrounding observation care. Due to these issues, and many others, the best and most patient centered way to simplify observation care is to eliminate it entirely.

Eliminating observation care would:

- Simplify hospitalizations for Medicare beneficiaries;
- Reduce the complexity of payment policies that surround a hospital stay;
- Allow hospitalists and other providers to focus on providing the care their patients need without the constraints of navigating unclear and confusing policies; and
- Ensure that hospitalized Medicare beneficiaries are eligible for post-acute SNF coverage if a provider deems it medically necessary.

If pursued, this approach would save the substantial costs related to inpatient admission decisions and to Medicare audit oversight on those decisions. It would also eliminate confusion and financial pressures for patients. If all patients admitted to the hospital were considered inpatients, all involved with the hospitalization, including patients, would have a clear understanding of the care being delivered, financial responsibilities, and post-acute coverage options.

We believe that CMS should use its authority to eliminate observation status and establish a much more patient-centered approach and that this could be done while remaining budget neutral to the Medicare Trust Fund. It would be important for CMS to work with stakeholders to mitigate any unintended administrative burdens and to ensure patients are still getting the care they need. We understand that Medicare would still need to provide coverage for care currently provided under observation, and offer the following options as potential solutions:

- Eliminating observation and rebasing or averaging DRG payments to account for the additional Part A Claims.
- Eliminating observation by developing a low-acuity DRG modifier that could be applied post-discharge rather than on admission to indicate when an admission is lower severity.
- Developing an Alternative Payment Model (APM) option that uses a capitated, bundled-payment, or some other approach to eliminate observation and streamline hospitalist/hospital payments.

Eliminating observation status is a clear opportunity to significantly reduce regulatory burden, costly administrative challenges, and ultimately reduce cost to the system while providing better, more patient centered care. It would create policies for hospitalizations that make sense to patients and therefore reduce stressors during already difficult times. It would allow physicians to focus their attention on the clinical needs of their patients, rather than the timing or status of their admission and whether they can

be safely discharged to medically-indicated post-acute care. SHM stands ready to work with CMS on implementing necessary changes to observation and looks forward to the response to this RFI.

Conclusion

SHM appreciates the opportunity to provide comments on the 2018 Physician Fee Schedule proposed rule and Request for Information on CMS Flexibilities and Efficiencies. If you require additional information or follow-up, please contact Josh Boswell, Director of Government Relations and General Counsel at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

A handwritten signature in black ink that reads "Ron Greeno MD". The signature is written in a cursive style with a large initial "R" and "G".

Ron Greeno, MD, FCCP, MHM
President, Society of Hospital Medicine