Society of Hospital Medicine
Empowering hospitalists. Transforming patient care.

1500 Spring Garden Street
Suite 501 • Philadelphia, PA 19130
P: 800.843.3360 • F: 267.702.2690
hospitalmedicine.org

October 5, 2020

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1734-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Verma,

The Society of Hospital Medicine (SHM), representing the nation's hospitalists, is pleased to offer our comments on the proposed rule entitled: *Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy (CMS-1734-P).*

Hospitalists are clinicians whose professional focus is the general medical care of hospitalized patients. They manage the inpatient clinical care of their patients while working to enhance the performance of their hospitals and health systems. Due to their focus on the hospital setting, hospitalists have been the backbone of the nation's COVID-19 response, caring for hospitalized COVID-19 patients throughout the country.

Most hospitalists are Board Certified in Internal Medicine or Family Medicine and practice exclusively in the hospital. The position of hospitalists within the healthcare system affords them a distinctive role in facilitating both the individual physician-level and hospital-level performance agendas. Furthermore, hospitalists' extensive work on the frontlines of the pandemic offer them a unique perspective on the proposals included in this rule.

Calculation of the CY 2021 PFS Conversion Factor; Budget Neutrality in the PFS

The CY 2021 Payment Policies under the Physician Fee Schedule (PFS) proposed rule provides for a correction to the long-standing underfunding of primary care

in the Medicare system. However, since all changes under the PFS are required to be budget neutral, CMS is required to offset these changes through the application of a budget neutrality adjustment on the entire PFS. CMS set the CY 2021 RVU Budget Neutrality Adjustment at -10.61 percent. Functionally, the budget neutrality adjustment results in a major decrease in reimbursement for inpatient, outpatient hospital and every other non-primary care service in the PFS. The cuts to inpatient care services will be devasting to hospital medicine groups.

SHM and the hospitalists we represent estimate the impact of the proposed budget neutrality adjustment in the PFS will lead to an approximate 8 percent decrease in their Medicare Fee for Service Revenue, which is similar to estimates for our specialty conducted by the AMA. This estimate puts hospitalists near the top of specialties slated to see reduced reimbursement under the CY 2021 PFS. We are confident the budget neutrality adjustment will have a profound negative impact on hospital medicine finances, and ultimately the care of hospitalized patients will suffer.

All of this comes at a time when hospitalists are going above and beyond to care for their patients during the pandemic. Hospitalist groups around the country prepared and responded immediately to the pandemic, adapting their group structures, learning how to treat a novel disease, and ensuring their hospitals remain prepared for current and future surges in their communities. In hearing stories from hospitalists who are on the front lines, it is hard not to be amazed at their resolve to care for as many patients as possible. Hospitalists reported working 10- to 12-hour days for 36 consecutive days, making very difficult medical and ethical decisions with limited resources, confronting shortages of personal protective equipment (PPE), fearing for their own safety and well-being, setting up and learning new processes, and standing up new hospital units and even entirely new hospitals devoted to COVID-19 care in a matter of days and weeks. As stated by one hospitalist who was at the center of the surge in New York City, "People gave their all without complaint. We hospitalists, and all those recruited to act as hospitalists, essentially took responsibility for the COVID response. This was, hopefully, the experience of a lifetime as a medical professional. I wouldn't want to ever experience something as daunting as this again."[1]

Hospitalists did all this work to prepare and respond to surges, even while inpatient patient volumes, and by extension, care reimbursement, dropped significantly. Despite financial help appropriated by Congress in the CARES Act earlier this year, hospitalist groups, like much of medicine, still face daunting financial challenges. As stated in the conclusion of a recent Health Affairs Article, "Health system leaders and public health authorities should be focusing on how best to ensure that patients with conditions that require hospital care obtain it during the pandemic."[2] A negative budget neutrality adjustment

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[1] NYC public hospitals rose to the demands of the COVID-19 crisis:
Hospitalists at the center of the storm. Larry Beresford. The Hospitalist. 2020. [cited 2020 Oct 4] Available from: https://www.the-hospitalist.org/hospitalist/article/227730/coronavirus-updates/nyc-public-hospitals-rose-demands-covid-19-crisis

[2] The Impact of the COVID-19 Pandemic On Hospital Admissions In The United States. John D. Birkmeyer, Amber Barnato, Nancy Birkmeyer, Robert Bessler, and Jonathan Skinner Health Affairs (Millwood) 2020. Vol. 39, No. 11,

would do the exact opposite. It will not only exacerbate instability and hinder care delivery when patients do seek inpatient care but also demoralize frontline physician responders caring for many of the sickest victims of the pandemic.

Additionally, hospital medicine practice goes hand-in-glove with the primary care continuum, as many illnesses treated in the hospital setting are related to uncontrolled chronic conditions. Hospitalists frequently aid their primary care counterparts by discovering and implementing needed changes in management of those chronic conditions. Like their outpatient primary care counterparts, hospitalists predominantly bill Part B PFS Evaluation and Management (E/M) visit codes. However, hospitalists only use codes designated for the hospital setting, many of which are undervalued just as the outpatient E/M codes. Indeed, we urged CMS to pursue changes to inpatient E/M codes concurrent with its work on outpatient E/M visits in 2018 and 2019. Instead of correcting or mitigating this problem, the proposed rule exacerbates the undervaluing of inpatient E/M codes.

SHM strongly urges CMS not to finalize this proposal without first addressing the inequities that it creates among providers, as well as the patient access issues that are likely to result from the budget neutrality adjustment. CMS may have the authority to address this issue under the Public Health Emergency. If so, SHM urges CMS to consider using that authority to blunt the impact of this conversion factor on the healthcare system. However, recognizing that legislative action may be necessary to adequately correct PFS code valuation, we request that CMS withdraw this proposal until a time when a more thorough and equitable solution can be realized.

Telehealth and Other Services Involving Communications Technology

The expansion of telehealth services throughout the duration of the Public Health Emergency (PHE) has been an effective tool to reduce the transmission of COVID-19, both among patients and between patients and providers. As hospitalists have faced shortages of personal protective equipment (PPE), the expansion of telehealth has helped to protect hospitalists and patients by minimizing transmission in the hospital setting. Furthermore, the increased payment rates for telehealth services has helped mitigate financial hardship resulting from the dramatic shifts in patient volumes and healthcare utilization. Hospitalists thank CMS for the flexibilities to date and we are pleased to offer our comments on additional telehealth proposals.

Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services from the Medicare Telehealth Services List

Hospitalists welcomed the rapid expansion of telehealth services as a result of the COVID-19 pandemic. Telehealth has been a valuable tool in delivering high quality care while protecting both patients and their providers. **To provide a pathway for continued flexibility around approved telehealth services SHM supports the creation of a Category 3 for purposes of adding services to the Medicare Eligible Telehealth Services list.** As hospitalists have adapted to the extensive use of telemedicine, extending telehealth flexibilities to the end of the calendar year in which the Public Health Emergency (PHE)

expires will help to ensure hospital systems and providers are not forced to dramatically shift their procedures immediately upon the expiration of the PHE.

To improve this proposal, SHM recommends that ALL services that have been added to the Medicare Eligible Telehealth Services list on a temporary basis during the PHE be added to the newly established Category 3. Many of the services that have been made telehealth-eligible as a result of the PHE were previously considered inappropriate for telehealth; however, the COVID-19 pandemic and the innovation it has forced has demonstrated that a number of these services can be provided in a high quality, patient centered manner via telehealth. While we recognize that, ultimately, not all Category 3 services can and should be added to Medicare's Telehealth Eligible Services List on a permanent basis, the proposal to exclude select services is premature. At this point, the PHE is still ongoing and there has been scant opportunity to examine data, reflect on what works via telehealth, what does not, and what novel processes have been developed that did not exist pre-PHE.

We agree that services added to the telehealth list under Category 3 will need to be assessed for permanent addition under Categories 1 or 2. Compiling and analyzing this data will take time. By broadening the scope of Category 3 services without exclusions, an opportunity will be created to truly examine the evidence for each service under Category 3. This is a unique opportunity to gather extensive data about the effectiveness and quality of telemedicine over a wide range of services and then, after examining all available evidence, decisions can be made on what services should be excluded and why. Further, the decision to exclude some services but not others from the proposed Category 3 will increase confusion around telehealth following the expiration of the PHE.

We specifically urge CMS to include the codes related to providing care in skilled nursing facilities (SNFs) and inpatient care facilities via telehealth for further evaluation as Category 3 services. CMS asserted in the proposed rule that the codes related to inpatient hospitalization and SNF care should not be included into Category 3 because permanent telehealth rules already allow for providers to bill for a telehealth visit once every three days. While well-intentioned, this policy cannot be operationalized efficiently and should not be a reason for Category 3 exclusion. Patients are admitted daily and cared for by many types of providers over the course of multiple hospital shifts, which makes it nearly impossible to keep track of which patients are eligible for a telehealth visit on any given day. CMS' longstanding opinion that patients should receive an in-person examination upon admission does have merit, but physicians should be allowed to use their professional judgment to determine what frequency of telehealth services versus in-person visits will best meet a patient's needs. Some patients may have multiple in-person examinations in the same day if they were, for example, transferred from the ED to the inpatient setting. In this situation, a telehealth visit upon admission may be appropriate. Safeguards would need to be established to ensure patients receive necessary in-person services, but the 'once every three days' policy as it currently stands cannot be realistically operationalized to the extent that warrants Category 3 exclusion.

In considering the timeframe for the Category 3 telehealth services list, SHM recommends that CMS consider extending coverage of the broader list of Category 3 services for a longer period, such as through the end of the year *following* the year in which the public health emergency ends. If the

COVID-19 PHE ends during 2021, then extending coverage of the Category 3 services only until the end of 2021 may not be sufficient to fully understand the impact of these telehealth services in the peri- and post- COVID health delivery system.

Moreover, there are many circumstances other than the COVID-19 pandemic in which remote inpatient visits and consultations may be the only safe or feasible option, such as during natural disasters, weather emergencies, and in recognizing that even upon the expiration of the PHE, there will still be local infectious disease outbreaks. **As policy continues to evolve around the delivery of telehealth, we encourage CMS to view telehealth as a means increase healthcare system capacity in both normal times and times of crisis.**

Quality Payment Program

MIPS Value Pathways (MVPs)

In the 2020 PFS Rule, CMS created the concept of a MIPS Value Pathway (MVP) to improve value, reduce confusion and burden associated with MIPS participation, and smooth the transition towards alternative payment models (APMs). We support this concept and urge CMS to continue developing MVPs so that they are meaningfully different from traditional MIPS reporting. To be successful, it is critical that MVPs align and unify the siloed categories of the MIPS, make appreciable reductions in administrative burden, and improve in the value proposition for participation in the MIPS.

We appreciate that CMS is extending the expected implementation time on MVPs, particularly with the disruption caused by the COVID-19 pandemic this year. However, it remains difficult to envision how an MVP will differ from traditional MIPS reporting, even with some of the more detailed framework and criteria laid out in this proposed rule. If the on-the-ground experience of the MIPS remains unchanged with MVPs, we question the utility of this pathway as a meaningful onramp towards APMs. We are concerned that some of the experiences reported by early MVP developers bear out our concerns that MVPs are not meaningfully different from the MIPS.

We continue to urge CMS to keep MVPs as an optional pathway for participation in the MIPS. Hospitalists have very heterogeneous experiences with MIPS participation that reflects the diversity of their practice structures, patient mix, and varied employment relationships with their hospitals and health systems. As a result, an MVP may not be the best or preferred way to engage with the MIPS for many hospitalist practices.

CMS also states that MVPs are meant to facilitate patient decision-making and provider selection. We agree that informed and data-driven decision-making by patients about their providers is vital to a patient-centric healthcare system. However, we remind CMS that for certain specialties, like hospital medicine, patients generally do not have choice in their inpatient provider. CMS' one-size fits all approach leaves hospitalists and similarly situated facility-based specialties to participate in a program that does not make sense for them or reflect the reality of their relationship with patients. **We ask CMS to build a more nuanced program that will address the fact that there are significant differences across physician specialties.**

SHM also encourages CMS to consider how MVPs could be used as tools to help address health disparities. Whether by creating new measures or instituting criteria for MVP developers, we believe the reduction of health disparities should be an important consideration for the development of the program moving forward. COVID-19 has laid bare many of the disparities that are endemic to the healthcare system and we must use this opportunity to learn and build performance measurement systems that improve health outcomes in marginalized and disproportionately impacted communities.

MVP Development Criteria

To guide the development of MVPs, CMS proposes a set of criteria for MVP developers to follow and to aid CMS' selection process. **While we support the concept of clear guiderails for creating MVPs, we urge CMS to not prescriptively use these criteria when selecting MVPs for inclusion in the program**. Some of these criteria may not be relevant or feasible for certain specialties and should not necessarily be a barrier for MVP consideration.

We also caution CMS that the sum of the MVP criteria appears to recreate the MIPS program in its entirety. They do not change some of the fundamental operational issues that have been experienced with the MIPS. CMS must ensure the MVPs meet the stated goals of reducing burden and facilitating movement towards APMs. It is not clear, given the details offered in the rule, that MVPs will achieve this aim.

Comments on specific criteria are offered below:

- *Utilization of Measures and Activities across Performance Categories*: CMS proposes to include a criterion that "MVPs should include the entire set of Promoting Interoperability (PI) measures." **We do not support this criterion as it conflicts with the needs of hospital-based providers who are exempt from the PI category in the MIPS.** This criterion creates a barrier that could impede the development of MVPs for hospital-based specialties.
- *Measure and Activity Linkages with the MVP*: Early MVP developers have reported conflicting messages around aligning measures and activities across the traditional MIPS categories in their respective MVP. If a quality measure and an improvement activity are aligned around the same clinical goal, we believe this will facilitate improved performance and should be encouraged within an MVP. Quality measures are meant to measure performance, while Improvement Activities are often meant to improve performance on those measure. We also believe it is counter to CMS' stated aim to reduce burden if similar measures and activities are not allowed within an MVP. **We ask CMS to clarify what they mean by "linkages" and encourage the use of similar measures and activities within MVPs**.
- *Measures and Improvement Activities Considerations*: **We are strongly opposed to CMS requiring that measures associated with the MVP be evaluated to ensure measure denominators have consistent eligible populations.** This requirement may prove difficult to achieve in an MVP constructed around a specific condition and would be nearly impossible for a hospitalist MVP. Hospitalists see a wide variety of conditions as part of caring for hospitalized

patients and even existing MIPS measures available to hospitalists are not aligned to be able to capture the same potential patient population.

Capturing the Patient Voice

SHM broadly agrees patients should be given information to make informed decisions about their health and healthcare providers. We note that patients do not always have a choice in their provider, such as when they are admitted to the hospital and see the hospitalist who is caring for patients at that time. CMS needs to develop a more nuanced program that accounts for the reality of the healthcare system in order to derive the most value and meaning for both providers and patients.

We also question how patients could be involved in the MVP development process for specialties that do not have parallel condition-specific patient advocacy groups. Hospitalists see a wide variety of patients and medical conditions that would be difficult to broadly engage on the development of an MVP. We encourage CMS to include phrases such as "as appropriate" or "as feasible" throughout sub criteria for Incorporation of the Patient Voice.

Timeline for MVP Implementation

SHM supports CMS' proposal to delay the implementation of MVPs to the 2022 performance period at the earliest. We believe it would be premature to commence MVPs without more detailed information about the pathway itself and more time is needed to allow a significant number of MVPs to be fully developed or in the pipeline.

Potential Hospitalist MVP

We encourage CMS to consider developing an MVP for hospital medicine that builds on the existing programmatic features for hospitalists. We recommend considering how CMS could incorporate the facility-based measurement option and the hospital-based exemption from PI into an MVP. SHM would welcome the opportunity to work with CMS on developing a hospitalist MVP to ensure it is a meaningful and valuable option for hospitalists.

APM Performance Pathway (APP)

CMS proposes to create an APM Performance Pathway (APP) in the 2021 MIPS Performance Year to make MIPS reporting for clinicians in APMs more consistent and predictable. This APP would replace the existing MIPS APM scoring standard. We appreciate CMS' candor about the technical challenges and complexity with the MIPS APM scoring standard and support moving towards a more simplified and streamlined way for APM participants who do not qualify as QP or partial QPs to participate in the MIPS. That said, we believe the APP as proposed has some of the same the operational challenges as the MIPS APM scoring standard.

CMS proposes to institute a set of quality measures for the APP (Table 41 in the proposed rule). **We do not support finalizing these measures for the APP**. This measure set would present a significant barrier for participation in the APP for hospitalists.

Hospitalists are very active in APMs, notably Bundled Payments for Care Improvement-Advanced (BPCI-A) and ACOs. The APP measure set is by and large not reportable by hospitalists. Hospitalists account for a significant number of BPCI-A participants and are, based on historical experience with the APM pathway, unlikely to qualify as QPs or Partial QPs and will therefore be subject to the MIPS. They would be unable to use the measure set proposed for the APP as only the Hospital-Wide, 30-day, All Cause Readmission measure is relevant to their practice. Hospitalists cannot report on CAHPS for MIPS (Quality ID 321), Diabetes: HbA1C Poor Control (Quality ID 001), Screening for Depression and Follow-Up Plan (Quality ID 134) and Controlling High Blood Pressure (Quality ID 236). This would leave hospitalists who are eligible for the APP to receive their entire Quality score on a single claims-based readmission measure. As proposed, the APP quality measure set would make this pathway unfeasible for hospitalists.

MIPS Final Score Methodology

CMS proposes several changes to the MIPS final score methodology to be responsive to the on-going COVID-19 pandemic. While we strongly support added flexibility to account for the disruption of the COVID-19 pandemic, we are concerned that the scale of disruption to the healthcare system and delay in the return to normalcy will cause on-going issues with reliable quality reporting and performance assessment.

CMS acknowledges that COVID-19 may significantly change clinical guidelines or measure specifications that could lead to challenges for providers submitting the measure or to yielding potentially misleading results. In response, CMS is proposing flexibility to allow them to assess a measure if there are 9 months of data available or suppress the measure if fewer than 9 months of data are available. **We expect measures will continue to be in flux for the foreseeable future and support this flexibility as proposed.**

SHM also encourages CMS to enable a simple way for measures to be flagged as problematic or out of date. Clinical processes have shifted dramatically and continue to evolve as providers adapt to the changing reality of patient care during the pandemic. In addition, measures may no longer be properly specified for patients or the clinical aspects of the measures may no longer be relevant. This is particularly salient as no quality measures that are currently in the program have any specifications to account for COVID-19 comorbidity.

CMS should be mindful that disruptions at the MIPS participant level may lead to significant issues with reporting on consecutive months of data. For example, a hospitalist group in a community that sees a significant spike in COVID-19 cases in March – May of 2021 would not be able to submit data for 12 or even 9 consecutive months. We urge CMS to keep these potential barriers to MIPS participation in mind and continue monitoring and adding flexibility as needed.

We support CMS' proposal to use Performance Year 2021 data to create benchmarks for 2021 performance. The dramatic disruption to the healthcare system during the national lockdown in early 2020 and the on-going surges of COVID-19 in communities throughout the United States makes using data from the 2020 performance year problematic. COVID-19 has and will continue to disrupt patient

volume, case mix, and patient outcomes. It would be impossible to compare data on quality performance and clinical outcomes during the pandemic to data prior to the pandemic.

Complex Patient Bonus

CMS proposes to double the complex patient bonus from a potential 5 points to a potential 10 points for the 2020 MIPS performance year/2022 MIPS payment year. **SHM supports CMS' proposal for doubling the complex patient bonus for the 2020 MIPS performance period as a simple but rough proxy to account for significant changes to patient comorbidity and complexity during the COVID-19 pandemic.** However, we advise CMS that HCCs or dual eligibility may not appropriately capture the challenges in caring for COVID-19 patients, particularly as many COVID patients were otherwise healthy prior to their infection. That said, these two criteria likely do represent a proxy for a significant portion of patients who disproportionately experience severe COVID-19 effects. We encourage CMS to continue to monitor the impact of the pandemic on quality measurement and to ensure that the complex patient bonus is targeting the communities most critically affected by COVID-19. If found necessary, we ask that CMS take further mitigating steps in subsequent rulemaking.

Establishing the Performance Threshold

CMS proposes to revise the previously established 60-point performance threshold to 50 points for the MIPS 2021 Performance Year/2023 Payment Year. **We support this reduction in the performance threshold**. While SHM encourages CMS to enable maximal flexibility in reaction to the COVID-19 pandemic, we are concerned about the jump from 50 points in 2023 to the mean or median in 2024, as required by statute. Earlier rulemaking estimated that the mean or median of MIPS performance and therefore the performance threshold in 2024 would be 74.01 points. **We urge CMS to develop a solution that continues a prolonged ramp for the performance threshold that does not require a 24-point increase from one year to the next.**

Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Groups

CMS proposes to replace the hospital-level Hospital-Wide All-Cause, Unplanned Readmission Measure (NQF #1789) with the re-specified Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Groups. This re-specified measure would address readmissions at the physician group level and focuses on high-risk conditions.

S**HM strongly recommends against adoption of this measure in the MIPS program**. We have broad-based concerns about the 30-day window for readmissions in CMS measures. Those concerns are heightened with the re-specification of the measure to apply to physician groups in the MIPS. There are numerous social, economic and logistical hurdles that can occur during a 30-day readmission window, many of which are independent of a physician's or group's behavior. If the measure window were shortened to 7 days, attribution would improve. With a shorter window, performance will be more closely linked to physician behavior and the relative "preventability" of a readmission would be more closely targeted. Recent articles in Health Affairs and Annals of Internal Medicine also support a

shortened 7 day window.[3,4] We believe that if CMS is going to have a readmissions measure specified at the physician group level in the MIPS, it needs to be more attuned to the ability of those groups to impact their performance on the measure.

APM Incentive Payment

SHM fully supports CMS' intention to move away from the fee-for-service payment in healthcare and incentivize the adoption of alternative payment models (APMs). However, under the current threshold requirements, this intent will not be fully realized. Many providers will remain unable to access the QPP incentive for Advanced APM participation given the lack of available Advanced APMs. For those who do manage to participate in a qualifying Advanced APM, the increasingly out-of-reach thresholds associated with qualifying for the incentive payment will give them pause.

The thresholds for Advanced APM participation in the 2021 performance year require greater than or equal to 75 percent of payments (either Medicare or all-payer) associated with the APM(s) in which the group is participating. This is an enormous barrier to achieving the APM incentive payment and relegates most hospitalists who are participating in APMs to continued participation in the MIPS despite their efforts and investment within an APM. **We urge the Center for Medicare and Medicaid Innovation (CMMI) to use its statutory waiver authority to its fullest extent to make the APM incentive pathway more accessible for providers and encourage greater movement away from fee-for-service Medicare.** We also note that there may be other statutory changes necessary to meet this goal and urge CMS to begin working now with Congress and other stakeholders to address any statutory changes that may be needed.

Conclusion

SHM appreciates the opportunity to provide comments on the 2020 Inpatient Prospective Payment System proposed rule. If you have any questions or need more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Danielle Scheurer MD

Danielle Scheurer, MD, MSCR, SFHM
President, Society of Hospital Medicine

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[3] Rethinking Thirty-Day Hospital Readmissions: Shorter Intervals Might Be Better Indicators Of Quality Of Care. David L. Chin, Heejung Bang, Raj N. Manickam, and Patrick S. Romano. Health Affairs 2016 35:10, 1867-1875

[4] Preventability of Early Versus Late Hospital Readmissions. Kelly L. Graham, Andrew D. Auerbach, and Shoshana J. Herzig. Annals of Internal Medicine 2019 170:3, 219-220