Society of Hospital Medicine

Empowering hospitalists.
Transforming patient care.

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March 1, 2019

United States Senate
Committee on Health, Education, Labor and Pensions
Washington, DC 20510-6300

Dear Chairman Alexander,

The Society of Hospital Medicine, on behalf of the nation's hospitalists, is pleased to respond to your December 11, 2018 request for recommendations to address America's health care costs. We agree with your assessment that healthcare costs are not adequately controlled, and that Congress should play a role in helping to address inequities and reducing unnecessary spending.

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. It is from these perspectives that we offer comments.

Observation Care—A Source of Significant Administrative Burden and Hidden Costs

Medicare's observation stay is a clear example of outdated policies that continue to require extensive administrative resources, stifle innovation and impede patient care. Since 2013, the Centers for Medicare and Medicaid

Services (CMS) has required that all hospital stays less than two midnights long be billed as observation. Medicare considers observation care to be an outpatient status, even though it is provided within the hospital walls, and in many cases, is virtually indistinguishable from care provided to inpatients. Since observation care and inpatient admissions are billed under different payment systems (Medicare Part B and Part A, respectively), providers must prospectively predict how long patients will need to stay in the hospital in order to bill for observation services. This feature of payment policy is unnecessary, illogical, and unrelated to caring for patients.

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 staff, time, and money 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.

Observation care also serves as a major impediment for patients getting the care they need. Time spent under observation care does not count towards the 3 midnights necessary to enable Medicare Skilled Nursing Facility (SNF) coverage. The Appendix ("Observation Time Never Counts Towards SNF Coverage") shows how under current rules, even four- and five-day long hospital stays may not grant patients access to Medicare SNF coverage. Instead of a policy where patients are able to get they care they need at the right level of care, patients and their providers must navigate an uncertain and confusing system. Lacking coverage for a necessary SNF stay, patients must determine whether to pay out-of-pocket for this care or opt out from going. In our experience, this fraught decision pits patient finances against their health and well-being and can ultimately lead to costly consequences for the healthcare system: readmissions, preventable complications and degradation of patient's health status.

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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.

We also note how the purpose and intent of observation care has shifted over time. When Medicare was first created, the average length of a hospital stay was approximately nine days.[4] Observation care was "a well-defined set of specific, clinically appropriate services, which include… treatment, assessment, and reassessment whether patients will require further treatment as hospital inpatients or if they are be discharged from the hospital..."[5] With a long expected length of stay in the hospital, the structure of observation care was a reasonable approach to figuring out where a patient needs to go next. Today, the average length of stay is about 4.6 days.[6] Many hospitalizations today are reimbursed entirely as observation services. While hospitalizations have gotten shorter, Medicare policy for admissions has not been updated to reflect current needs and clinical realities.

The "observation versus inpatient" decision is a payment policy irreflective of patient care. It requires administrative burden, enormous cost, and yields no clinical benefit. We believe this is an excellent opportunity for Congress to simplify Medicare's rules and eliminate confusion about patient admission status.

Barriers to Alternative Payment Model (APM) Adoption

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 seeks to incentivize providers to move away from fee-for-service (FFS) Medicare towards Alternative Payment Models (APMs). It provides exemption from the Merit-based Incentive Payment System (MIPS) and a 5 percent lump sum incentive payment through 2024 for qualified providers in APMs. To determine whether a provider qualifies for the APM pathway of MACRA, the law established thresholds of payment or patients. In 2019 and 2020, the thresholds are set at 25 percent of Medicare payments; 2021 and 2022 at 50 percent; 2023 and beyond at 75 percent. For patient count, providers must meet generally similar thresholds in each year. Starting in 2021, the thresholds may be met through an all-payer analysis, though providers must still reach a minimum threshold of Medicare payments or patients. We understand the law specified these thresholds to ensure that providers are meaningfully engaged with the APM and have moved significantly away from FFS Medicare.

SHM believes that encouraging providers to move into APMs is the most important aspect of MACRA. We see APMs as the only pathway away from the costly FFS system. APMs are also important because they return a significant amount of control directly to providers. That said, the threshold model of APM participation creates a major barrier for many providers, leaving them stuck in traditional fee-for-service Medicare and the MIPS. Small fluctuations in patient mix can result in providers qualifying as APM participants one year and not the next. In addition, some of the APM models, such as Bundled Payments for Care Improvement (BPCI) Advanced, are condition-based, meaning generalists like hospitalists will be unable to collect enough payments or patients to meet the threshold. In the original BPCI, hospitalist

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[4] U.S. Bureau of the Census. Statistical Abstract of the United States, 1966. 87th Annual Edition. Washington, DC: 1966.
[5] Centers for Medicare & Medicaid Services. (2014). Medicare Benefit Policy Manual, Chapter 6: Hospital Services Covered under Part B. (CMS Publication Rev. 182). Baltimore, MD
[6] Freeman WJ, Weiss AJ, and Heslin KC. "Overview of U.S. Hospital Stays in 2016: Variation by Geographic Region." Agency for Healthcare Research and Quality: Healthcare Cost and Utilization Project. Accessed via https://www.hcup-us.ahrq.gov/reports/statbriefs/sb246-Geographic-Variation-Hospital-Stays.jsp.

participants that engaged with 12 different conditions in the model were unable to meet even the lowest thresholds set for the program.

We believe the thresholds serve as an impediment to meeting the intent of MACRA and, importantly, are a barrier to cost containment. Well-designed APMs have the potential to save a significant amount of money for the Medicare Trust Fund, while the budget-neutral MIPS does not share the same potential. To save on cost, we must significantly increase the focus and incentives aimed at moving more providers off of fee-for-service and onto APMs.

Pay for Performance: Are We Measuring the Right Things?

Measurement has become a central feature of the Medicare system. The use of measurement in pay-for-performance programs is built around an assumption that measurement can lead to improvements in quality and reductions in cost. SHM agrees that well-designed measures have the potential to yield these outcomes and may be worth the time, work, and cost to implement. Looking at the MIPS, current policies create a complicated program with measures that give providers very little meaningful and actionable feedback. Providers spend a significant amount of time and money on reporting quality measures that may not be reflective of their entire practice or even capture most of their Medicare patients. Instead, they are participating in the MIPS as a compliance effort to avoid significant penalties.

We believe there is a significant opportunity to step back from siloed and ineffective quality and cost measures and focus on developing indicators for the quality and safety of healthcare more broadly. Such indicators would monitor the general health and well-being of communities. Ideally, this would establish a level of shared accountability between providers on improving these broad indicators and will lead to the proliferation of much more coordinated local-level quality improvement and cost-reduction efforts. This systems-based approach, while it does not contain the most narrowly tailored measures to specific specialties or individual clinicians, is how patients view the healthcare system and is ultimately how providers must work together to improve quality and decrease costs. We believe the goal of the MIPS should be to align incentives and establish simple and clear markers that are shared across providers and specialties.

SHM stands ready to work with the Senate HELP Committee on lowering healthcare costs and driving innovation in the healthcare system. If you have any questions or need more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org.

Sincerely,

Nasim Afsar

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President, Society of Hospital Medicine