Society of Hospital Medicine
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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

The Society of Hospital Medicine (SHM) is writing as a follow-up to our February 23, 2022 meeting with CMS staff regarding the new Split (or Shared) Billing Policy promulgated in the 2022 Physician Fee Schedule final rule (CMS-1751-F). In this meeting, we raised concerns about the implementation of the policy and shared on-the-ground perspectives from hospital medicine groups as they work to comply with the regulation.

SHM is the national association for hospitalists, who are physicians that work primarily in acute care hospitals and provide the general medical care for most hospitalized patients nationwide. As a result, hospitalists have been at the frontlines of the COVID-19 pandemic, caring for a large proportion of hospitalized COVID patients. Many hospitalists also serve in leadership roles, helping to shape their hospital systems' response to COVID surges in their communities. Hospitalists are typically trained in internal medicine, family medicine, or pediatrics, although some have elected to identify themselves in PECOS as hospitalists using the recently created Medicare specialty designation. SHM estimates there are more than 44,000 adult hospitalists, making hospital medicine one of the largest specialties of physicians nationwide.

Hospitalists are longstanding proponents of team-based care, working hand-in-hand with nurse practitioners and physician assistants to care for hospitalized patients. Physicians and advanced practice providers (APPs) have distinct training and skillsets. When working together, their skills complement each other, enabling hospital medicine teams to meet the needs of their patients efficiently and effectively. The interprofessional relationships between physicians and APPs in hospital medicine groups have evolved and developed over time, steadily improving collaborative processes to improve patient outcomes, care processes, and institutional systems. We are already seeing the current split (or shared) billing policy is disrupting and dismantling current models of team-based care that have taken years to build.

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It is our understanding that the proposed, and subsequently finalized, split (or shared) billing policy arose from a request to rescind long-standing Medicare manual sections covering the same topic. As part of an update to the since-rescinded policies, the new split (or shared) billing policy placed sole emphasis on *time* to differentiate whether a physician or an advanced practice provider (APP) should bill for a shared patient's care. The finalized policy allowed 2022 to be a transition year; full implementation of the time-based standard would go into effect in 2023.

We urge CMS to reconsider this policy in light of the extraordinary disruption that hospital medicine groups are experiencing as they try to navigate these new rules. **Specifically, we ask CMS to rescind the current split (or shared) billing policy, propose an alternative policy, and work with stakeholders to identify reimbursement policies that support interprofessional team-based care.** The time-based criteria now being used to define "substantive portion" of the visit is upending years-long interprofessional relationships and carefully coordinated team structures. In our experience, patients who have shared visits benefit from the expertise, experience, and different skillsets of the hospitalist physician and the hospitalist APP. The split (or shared) billing policy reduces these complex interactions into a binary that is not reflective of high-quality patient care.

As hospitalist groups have begun to implement the split (or shared) billing policy, our members report three general experiences:

1. APPs become increasingly delegated to non-RVU producing roles or are limited to performing scribe-like functions;
2. Shift towards greater, fully independent practice for APPs (where possible), limiting the amount of collaborative, team-based work with physicians; or
3. Shift away from the use of APPs to focus instead on physician-level care.

All these outcomes adversely disrupt the team-based approach to hospital medicine and will negatively impact the care of hospitalized patients. APP skillsets will either be underutilized, or physicians will be discouraged from collaborating with APPs on complex cases, as physicians will be unable to bill for their contributions. We have not, to date, heard from any hospitalist groups indicating that implementation of this policy is not disruptive.

Inadequacy of Time as a Criterion

The Medicare fee for service system has long used time as an option for billing Evaluation & Management (E&M) codes. Time based billing works well in settings like an outpatient office, as time spent on a visit is more easily tracked. In the inpatient setting, however, time is rarely used to bill for visits. There are some exceptions, including discharge codes and critical care codes, which are structured as time-based. Generally, however, the discontinuous nature of care in the hospital includes balancing multiple patients, working with many different professionals across specialties and provider types, and seeing patients at multiple points throughout a day, makes it extremely challenging for time to be accurately and consistently tracked for billing purposes. Additionally, the time physicians and APPs spend on any given case should not be equally weighted, as they possess different skillsets, expertise,

and training. The finalized rule treats all time equally and assumes time can and will be measured consistently. We do not agree with this formulation as it is not reflective of how inpatient care is delivered.

Most hospitalists bill Medicare hospital visit E&Ms using medical decision making (MDM). MDM synthesizes the other components of the E&M visit to create a treatment plan and adjust to new information or developments in the care of the patient. We believe this billing model may be more appropriate for split (or shared) visits than time-based billing, as MDM places a greater emphasis on clinical decisions and the course of a patient's care. **We encourage CMS to work with stakeholders on how to assess when decision-making is shared and how to determine who is the primary manager of patient care.**

We note that the transition year (2022) allows split (or shared) billing using MDM or other components of the E&M visit instead of time. However, this transition policy requires the billing provider to perform that component in its entirety. **We disagree with the transition-year policy that only allows MDM or other components of the visit to be used if the billing provider performs the entirety of the component and do not believe this should be included in an alternative policy.** This requirement is contrary to the spirit of team-based care, and in many cases requires significant rework and additional documentation burdens.

Devaluation of Teamwork and Expertise

One significant and immediate consequence of the split (or shared) billing policy is the devaluation of expertise and training. Our members shared an analogy in the legal field that demonstrates the devaluing of physician expertise. When contracting with a law firm on a case where both a partner and an associate provide services, the rate paid for the partner's contributions would be at the partner's rate, not the associate's—even when the partner is doing only a small amount of the work. The split (or shared) billing policy creates the opposite effect. In cases where the APP would have more than fifty percent of the time associated with the patient visit, CMS is paying for the expertise of both the APP and the physician at the reduced APP rate.

There are some patient cases in hospital medicine where the APPs are managing the care of the patient, with very limited physician involvement. These are and should be billed by the APP. However, that is not the majority of cases that involve team-based care. In situations where there is more shared decision-making and more direct physician involvement, we believe it would be appropriate for the physician to be reimbursed accordingly.

Working Towards a New Standard of Team-Based Care

We urge CMS to continue working with stakeholders to identify a reasonable and efficient way to reimburse for team-based care and ensure that providers are being paid when they are contributing to the care of a patient. As CMS staff noted in our meeting, the fee for service system does not and cannot effectuate "team" reimbursements—they are billed by a single person. That said, CMS can and should take steps to ensure that its policies are not actively inhibiting or disincentivizing team-based care.

We believe that a more realistic standard would allow a physician to bill for a split (or shared) visit when they "meaningfully contribute" to the care of the patient. Practically speaking, this would focus more attention on the medical decision making for the patient and would be captured in normal required documentation in the electronic medical record. "Meaningfully contribute" could include directly managing care of the patient, altering the care plan for the patient, shared decision-making with the APP, or other non-token involvement with the patient or APP. We believe this would not include the physician "poking their head in" as referenced in the rule or other forms of token involvement in caring for these shared patients.

In our meeting, CMS staff asked for ways that standard not based on time could be audited. CMS performs audits and reviews records through contractors as part of their normal program integrity work. Any medical record can be reviewed for substantiating evidence that a physician appropriately billed for a split (or shared) visit. We are unclear why CMS does not believe these same tools could be used to protect the Medicare Trust Fund from inappropriate split (or shared) billing.

Conclusion

We strongly urge the agency to revisit and change the split (or shared) billing policy finalized in the 2022 Physician Fee Schedule final rule. Early efforts at implementation have led to drastic changes in team-based care, upended physician/APP relationships, and contributed to significant new administrative burdens, all of which is to the detriment of care for hospitalized patients. We appreciate CMS' willingness to engage with stakeholders about this policy and look forward to continuing the conversation. If you have any questions or need more information, please contact Josh Boswell, Chief Legal Officer, at jboswell@hospitalmedicine.org.

Sincerely,

Jerome Siy, MD, MHA, SFHM
President, Society of Hospital Medicine

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