January 30, 2019

Kate Goodrich, MD, MHS
Director of Center for Clinical Standards and Quality
CMS Chief Medical Officer
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Dr. Goodrich:

The Society of Hospital Medicine (SHM) the Infectious Diseases Society of America (IDSA), the American College of Emergency Physicians (ACEP), the Emergency Department Practice Management Association (EDPMA), and the American Society of Anesthesiologists (ASA) representing the nation's hospital medicine, infectious disease, emergency medicine, and anesthesiology professionals, is writing to ask for review and change to the definition of hospital-based group in the Promoting Interoperability (formerly Advancing Care Information) category of the Merit-based Incentive Payment System (MIPS).

Hospital-based providers are exempt from the Promoting Interoperability (PI) category in the MIPS. This policy acknowledges that these providers are working in settings that use Certified Electronic Health Record Technology (CEHRT) and participate as providers working in eligible hospitals in the Promoting Interoperability Program (formerly EHR Incentive Program). It prevents unnecessary duplication and excessive administrative burden practices that work primarily in the hospital. We note the policy is meant to account for how hospital-based providers are already doing work for their hospitals to meet similar or identical requirements in the eligible hospital Promoting Interoperability Program. Furthermore, it protects hospital-based providers from being penalized for factors outside of their control, since they do not always have full access to or influence over the CEHRT used in their hospitals.

To determine whether a MIPS eligible clinician (defined as a unique Taxpayer Identification Number-National Provider Identifier (TIN-NPI) combination) is exempt from PI as a hospital-based provider, the Centers for Medicare and Medicaid Services (CMS) uses a threshold of 75 percent of covered professional services in Place of Service (POS) codes for off-campus outpatient hospital (POS 19), inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or emergency room (POS 23) during a 12-month determination period. If a MIPS eligible clinician meets or exceeds this threshold, they are exempt from the PI category and the category weighting is reallocated to the MIPS Quality category.

To determine whether a group is exempt as a hospital-based group, CMS has indicated that 100 percent of the eligible clinicians associated with the group must be designated as hospital-based during the same 12-month determination period. This extremely restrictive definition is inconsistent with the overarching intent of the hospital-based PI exemption as it requires groups that have only a single provider whose billing deviates from the exemption to participate in PI.

The current definition of a hospital-based group is leading to significant and unfair reductions in overall MIPS scores for many of our groups and will continue to be a problem in future years. These groups have already reported unexpected reductions in their first year (Payment Year 2019) total MIPS score due to this policy. **As such, we recommend CMS establish a policy that is aligned with the definition of**

hospital-based MIPS-eligible clinicians and in parity with the facility-based group in the facility-based measurement pathway and the non-patient facing group exemption pathway of the MIPS. Such policy would not only better conform to the on-the-ground realities of hospital-based group practice, but also would eliminate the confusion, and unnecessary administrative burden associated with the current policy. **We ask CMS to make this policy change effective with the 2020 payment year of the program.**

Lack of Clarity in the Rulemaking

CMS promulgated the hospital-based designation and its relationship to the Advancing Care Information category in the 2017 rule entitled Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. Because the prior Medicare EHR Incentive Program for eligible clinicians assessed performance at the individual level, CMS did not have a group reporting feature; instead groups could submit their individuals' reporting as a batch. For the first performance year of the MIPS, CMS finalized policies for how group reporting would function in the Advancing Care Information performance category. In the rule, CMS states:

> Under this option, we proposed that performance on advancing care information performance category objectives and measures would be assessed and reported at the group level, as opposed to the individual MIPS eligible clinician level. We note that the data submission criteria would be the same when submitted at the group-level as if submitted at the individual-level, but the data submitted would be aggregated for all MIPS eligible clinicians within the group practice. … As with group reporting for the other MIPS performance categories, to report as a group, the group will need to aggregate data for all the individual MIPS eligible clinicians within the group for whom they have data in CEHRT. For those who choose to report as a group, performance on the advancing care information performance category objectives and measures would be reported and evaluated at the group level, as opposed to the individual MIPS eligible clinician level. For example, the group calculation of the numerators and denominators for each measure must reflect all of the data from all individual MIPS eligible clinicians that have been captured in CEHRT for the given advancing care information measure. … After consideration of the comments, we are finalizing our proposal to allow group reporting for the advancing care information performance category with the additional explanation of data aggregation requirements for group reporting provided in our response above, particularly as it relates to aggregating unique patients seen by the group.[1]

This section is neither clear in how group assessment will function, nor does it contain an explicit reference to the policy that 100 percent of the providers must be hospital-based for the group to be considered hospital-based. We also note that CMS does not propose or finalize a definition of hospital-based group in the section of the 2017 rule pertaining to Hospital-Based MIPS Eligible Clinicians.[2]

In the final rule entitled Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, CMS responded to a commenter asking for CMS to change their policy and reweight the advancing care information category to zero percent for any group or virtual group in which the majority of individual clinicians would be exempt from scoring in that category. CMS writes as commentary:

[1] 81 FR 77215
[2] 81 FR 77238

> We did not propose any changes to our policy related to MIPS eligible clinicians in groups. We were simply restating the policy finalized for groups reporting data for the advancing care information performance category as described in the CY 2017 Quality Payment Program final rule (81 FR 77215) that group data should be aggregated for all MIPS eligible clinicians within the group. This includes those MIPS eligible clinicians who may qualify for a zero percent weighting of the advancing care information performance category based on a significant hardship or other type of exception, hospital-based or ASC-based status, or certain types of nonphysician practitioners (NPs, PAs, CNSs, and CRNAs). Our policy is 100 percent of the MIPS eligible clinicians in the group must qualify for a zero percent weighting in order for the advancing care information performance category to be reweighted in the final score. (82 FR 53687)

The language in the 2017 rule is not stated as asserted in the 2018 rule. There was no discussion in either rule as to how scoring would function in a group where a significant number of providers were exempt from the advancing care information category. Indeed, CMS' current position means that the hospital-based exemption is meaningless for providers in these groups.

This hospital-based group policy does not reflect the spirit or intent of Section 1848(o)(1)(C) of the Social Security Act, which states that Incentives for Adoption and Meaningful Use of Certified EHR Technology would not be applied to hospital-based eligible professionals. The Act defines a hospital-based eligible professional as "an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital."[3] We believe this '*substantially all*' standard should apply to group-level determinations as well.

We believe the agency was not clear in its rulemaking and did not adequately consider the unintended consequences of the hospital-based group policy.

Policy Does Not Reflect Practice Staffing Realities

This policy unfairly penalizes hospital-based groups because it does not align with how these groups are structured and how they operate on a day-to-day basis. Our groups staff their practices for 24-hour coverage in the hospital. There are three dynamics that affect staffing with implications for the MIPS hospital-based group policy: widespread shortage and high turnover of trained clinicians, locum tenens and moonlighting physicians, and expansion of providers' roles.

The United States healthcare system faces a serious and widespread scarcity of trained physicians. The most recent study by the Association of American Medical Colleges indicates that the shortage of physicians will be upwards of 120,000 by 2030.[4] Our specialties are no exception to this problem. For example, we estimate that more than half of hospital medicine groups have at least one unfilled position through the year.[5] Many of these unfilled positions are due to turnover of existing staff. The median turnover rate for hospital medicine groups is 7.4% of their staff[6], suggesting a continual churn of

[3] Section 1848(o)(1)(C)(ii) of the Social Security Act.
[4] Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections from 2016 to 2030: 2018 Update. https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/
[5] 2018 State of Hospital Medicine Report. Society of Hospital Medicine.
[6] Ibid.

staff throughout the year and year-over-year. These staffing issues are commonplace across our specialties. As a result, group practices turn to a variety of strategies to ensure adequate coverage throughout the year.

Beyond staffing shortages, even fully-staffed groups need to find ways to address unforeseen gaps in their practice, such as illnesses or unplanned leaves of absence. As a result, many groups must engage with locum tenens providers throughout the year. In hospital medicine, more than 44% of groups use locum tenens physicians to cover unfilled hospitalist physician positions.[7] Large groups may have locum tenens teams that help provide coverage across the group's many practices. Other groups may contract with locum tenens companies to provide these services as needed.

By using locum tenens providers, these groups have additional National Provider Identifiers (NPI) in their TINs that may have unexpected billing patterns. Some of these TINs are structured in a way that the work of these locum tenens providers includes outpatient work. As such, an exclusively hospital medicine TIN may have a single provider who fails to meet the definition of hospital-based. The group, reporting as a group, would therefore be held accountable for the performance in PI, despite the circumstances and ability for the group to participate in the category remaining unchanged. Due to unplanned changes in staffing, the need for locum tenens providers in a given year is unexpected. In effect, these providers, while critical to the day-to-day functioning of the group, are temporary workers that have an outsized impact on the overall MIPS performance of the group.

Moonlighting presents identical issues as locum tenens providers. For example, nearly 60% of hospitalist groups use moonlighting to cover unfilled hospitalist physician positions throughout the year.[8] Hospitalists are predominantly board certified in Internal Medicine or Family Medicine, meaning these moonlighting providers may practice in both the inpatient and outpatient settings. Again, the presence of a single outpatient provider who is moonlighting in the hospitalist TIN can trigger the requirement for the entire hospitalist group to participate in PI.

Adding to the issues with this policy, the scope of some of our specialties continues to expand to meet the needs of our patients. For example, it is not uncommon for hospitalists to extend their practice by following patients into outpatient settings, such as step-down clinics, post-discharge clinics, and skilled nursing facilities. In most hospitalist groups, these providers and their billing patterns would be a significant minority of the group's practice. However, due to the definition of a hospital-based group for purposes of PI, these patient-centered expansions in scope of care will require the group to participate in PI.

Like hospitalists, the role of emergency physicians has also expanded beyond the walls of the hospital. There are many cases where a member of an emergency medicine group works in multiple settings. For example, an emergency physician might work two days a week at an urgent care center in order to provide additional staffing due to a colleague's maternity leave or due to a flu epidemic. In rural areas especially, an emergency physician may need to work in an urgent care or office-based setting to meet the needs of the community. This restrictive and inflexible policy penalizes the entire group and does not reflect the needs of patients or communities.

Our groups—that is groups that practice predominantly in the hospital—do not expect to be held accountable for PI in the MIPS. Indeed, it is neither feasible nor reasonable for CMS to expect these

[7] Ibid.
[8] Ibid.

groups to be able to report performance in the PI category. They do not control the availability of CEHRT in the hospital and, given the limited number of providers in their groups that bill in outpatient settings, the group cannot be expected to control the availability of CEHRT in those other settings. Even if those settings are using CEHRT, the group will not be able to influence whether that system is reporting PI for that individual. As a result, groups in this position receive a zero in the PI category for the entire group.

We recognize that groups decide whether to report as a group or as individuals. However, reporting as individuals would be a significant administrative burden, particularly for those groups who have reported as part of a group in the past. In addition, disincentivizing group reporting undermines the ability for these groups to invest in system-wide quality improvement programs and infrastructure. While we also recognize that hardship exceptions may be available to the individuals within these groups who may not otherwise meet the hospital-based definition, the need to complete an application can be unpredictable, will not be apparent for an otherwise hospital-based group, and administratively burdensome, if not impossible, for a group to track. These are not sustainable options for our groups' participation in the MIPS.

Concerns about Fidelity of TIN Structures

We also want to verify with CMS that the calculation for individual hospital-based designation is based on a clean analysis of a single TIN-NPI combination as defined in the regulation. We are concerned that the analysis may include billing for an NPI across the TINs in which it bills due to the fluid nature of our groups and the relative ease at which providers may practice in both the inpatient and outpatient settings. Errors in this analysis may also affect a TIN's designation as a hospital-based group, inadvertently requiring participation in the PI category.

Consequences of Current Policy

Current policy has already significantly impacted our groups. Many groups who elect to report as a group in the MIPS were surprised by the inclusion of a score in the PI category. Others that knew certain providers may trigger PI requirements did not have the tools or ability to report in the category for that provider. In addition, even groups with advance knowledge of the potential for reporting in PI are not able to plan when they might use a locum tenens provider or moonlighting physician and be able to meet the reporting requirements. Because of their variable engagement with these providers, groups are not even be able to plan for a hardship exception application from the category for affected providers and missed hardship exception application deadlines.

In the examples below, we show the disproportionate impact of the existing hospital-based group policy. A typical group of twenty providers has nineteen providers who have the hospital-based designation, and one provider who does not. The group reports as a group and does not report anything for PI. Figure 1 shows the impact on overall scoring under current policy.

Figure 1. Example MIPS Scoring for Group Under Current Policy (2020 Payment Year)			
MIPS Category	Category Weighting	Category Score	MIPS Points
Quality	50%	50%	25
Cost	10%	50%	5
Improvement Activities	15%	100%	15
Promoting Interoperability	25%	0%	0
Total MIPS Score			45

Figure 2 shows the same group's performance if the definition of hospital-based group were changed to align with the individual definition of facility-based. This policy would designate groups as hospital-based if 75% or more of the individuals in the group are designated as hospital-based. As a result of the recommended policy change, our example group would be classified as hospital-based.

Figure 2. Example MIPS Scoring for Group Under Recommended Policy (2020 Payment Year)			
MIPS Category	Category Weighting	Category Score	MIPS Points
Quality	75%	50%	37.5
Cost	10%	50%	5
Improvement Activities	15%	100%	15
Promoting Interoperability	0%	N/A	0
Total MIPS Score			57.5

Based on this example, a single provider failing to be hospital-based causes groups to lose a significant number of points in the Total MIPS Score under the existing definition. Under current payment adjustment rules and the MIPS performance threshold in Years 1 and 2, this decreases their potential positive payment adjustment under the MIPS. In future years, we expect this policy will lead to groups receiving negative payment adjustments as their performance sinks below the MIPS performance threshold.

Out of Alignment with Facility-Based Group Measurement and Non-Patient Facing Groups

CMS has promulgated two policies that offer a roadmap for changing the definition of hospital-based group. The definitions of a facility-based group and a non-patient facing group similarly build on the definition of individuals within these special statuses. Group reporting under these two statuses opens a set of reporting and scoring rules that changes how they participate in the MIPS. The current definition of hospital-based group diverges significantly from these definitions and excludes many groups that we believe should be covered by the policy.

Most recently, CMS defined a facility-based group in the CY 2018 Quality Payment Program final rule.[9] A facility-based group is a group in which 75 percent or more of its NPIs meet the definition of facility-based as individuals. Facility-based individuals, as changed in the CY 2019 Physician Fee Schedule and Quality Payment Program rule, are defined as providers who bill 75% or more of their covered professional services in Place of Service 21, 22, or 23, and bill at least a single service in Place of Service 21 or 23, and work in a facility that receives a Hospital Value-based Purchasing Score.[10] Facility-based group status generates a facility-based score for the group in the Quality and Cost categories.

CMS also created a special status for MIPS eligible clinicians and groups for non-patient facing providers. In the CY 2017 Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule final rule with comment period, CMS established a definition for a non-patient facing group.[11] The rule indicated that non-patient facing group are designated when more than 75 percent of the NPIs billing under the group meet the definition of non-

[9] 82 FR 53757
[10] 83 FR 59452
[11] 81 FR 77008

patient facing as individuals. This special status engenders a set of reporting and scoring rules, including exemption from the PI category.

The 75 percent thresholds associated with these two policies acknowledge the small variations in group practice that would otherwise serve as barriers to meeting the designation. They also indicate an awareness that these small practice differences should not prevent these groups from accessing the special rules and standards associated with the status. We believe these same considerations should guide changes to the definition of hospital-based group. Furthermore, alignment of hospital-based group with facility-based measurement and non-patient facing policies will establish a consistent definition that would decrease confusion and simplify providers' decision-making process.

Recommended Solution

We ask CMS to align the policy for designating a hospital-based group with those of non-patient facing and facility-based groups. Further, we ask CMS to use its rulemaking authority to make this change applicable to 2020 payment adjustments.

This exemption could be phrased as follows: Groups are considered hospital-based if more than 75 percent of their clinicians meet the individual hospital-based exemption (75 percent of covered professional services in Place of Service (POS) codes for off-campus outpatient hospital (POS 19), inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or emergency room (POS 23) during a 12-month determination period). A hospital-based group is automatically reweighted and does not need to submit a Quality Payment Program Exception Application.

Without this change, the definition of hospital-based group causes significant and unnecessary harm to physician practices who are otherwise making good faith efforts to participate in the MIPS program.

Conclusion

Our organizations stand ready to work with CMS on finding a solution for hospital-based groups. If we can provide more information, please contact Josh Boswell, Director of Government Relations at the Society of Hospital Medicine, at 267-702-2635.

Thank you for your time and attention to this matter.

Sincerely,

Society of Hospital Medicine

Infectious Diseases Society of America

American College of Emergency Physicians

Emergency Department Practice Management Association

American Society of Anesthesiologists

cc: Molly MacHarris, Program Lead, Center for Clinical Standards and Quality