Society of Hospital Medicine
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Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Administrator Verma,

The Society of Hospital Medicine (SHM) is pleased to offer the following comments on the proposed rule entitled: *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices* (CMS-1677-P) published by the Centers for Medicare and Medicaid Services (CMS) in the Federal Register.

SHM represents the nation's nearly 57,000 hospitalists whose professional focus is the general medical care of hospitalized patients. Hospitalists are front-line healthcare providers in America's hospitals for millions of patients each year, many of whom are Medicare and Medicaid beneficiaries. They manage the inpatient clinical care of their patients, while working to enhance the performance of their hospitals and health systems. The unique position of hospitalists in the healthcare system affords a distinctive role in facilitating both the individual physician-level and systems or hospital-level performance agendas.

SHM shares CMS' vision of promoting high quality care, improving outcomes, and streamlining care coordination for Medicare beneficiaries. After reviewing the proposals, we offer the following comments on policies for the Hospital Readmissions Reduction, Hospital Value-Based Purchasing, Inpatient Quality Reporting, and Hospital Acquired Condition programs. We also welcome the opportunity to respond to the Request for Information on CMS Flexibilities and Efficiencies.

Hospital Readmissions Reduction Program: Proposed Updates and Changes

As part of the implementation of the *21st Century Cures Act*, CMS is proposing to develop a sociodemographic status risk adjustment methodology in the Hospital

Readmissions Reduction Program. This methodology will create peer comparison groups for hospitals by using their proportion of dual-eligible (Medicare and Medicaid) patients. SHM has consistently supported adjusting for sociodemographic status in measures throughout CMS' programs and believes this effort in the Hospital Readmission Reduction Program is a good first step.

CMS asks for feedback on their proposed methodology for assigning hospitals to peer groups for purposes of comparison and offered three different options: two groups, quintiles, or deciles. **Based on a review of CMS' analysis, SHM views the creation of quintiles as the best of the presented comparison group options to avoid disadvantaging safety net hospitals and other institutions that serve high-risk populations.** However, we encourage CMS to remain watchful for unintended consequences and open to feedback and future changes if issues do arise.

Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes

Proposed New Measure for the FY 2022 Program Year and Subsequent Years: Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN Payment)

SHM remains concerned about CMS' efforts to add episode-based payment measures while maintaining broader spending measures, such as the Medicare Spending Per Beneficiary (MSPB) measure. **Therefore, we oppose the addition of the PN Payment measure at this time.** Services assessed in the PN Payment measure overlap with services counted towards these broader spending measures and, as such, scoring and payment adjustments are based on the double-counting of services.

We agree with CMS that these episode-based measures address areas with high variation and high-volume clinical conditions, and that there is a potential for improvement. However, the value gained from measuring and assessing these conditions does not negate the inherent inequity in counting and analyzing services twice under different measures. We strongly disagree with CMS' assertion that performance on episode measures is not predictive of performance on broader spending measures. CMS has cited high-volume clinical conditions as a primary rationale behind adopting episode-based payment measures, including PN Payment. Episode-based measures for high volume, or high cost, conditions would logically make up a larger proportion of services and costs in broader cost measures, thereby affecting performance rates. At a minimum, we ask CMS to provide more detailed analyses in proposed rules to ensure that measures and performance assessments are applied evenly and fairly.

Proposed Changes to the Hospital-Acquired Conditions (HAC) Reduction Program

Request for Comments on Additional Measures for Potential Future Adoption

CMS asked for feedback on additional measures for the HAC Reduction Program, including the adoption of measures around the following areas:

- falls with injury;
- adverse drug events;
- glycemic events;
- and ventilator-associated events.

Of these areas, SHM believes adverse drug events and certain glycemic events are worth monitoring and measuring, particularly if the measures used are specified to target preventable events or errors. Additionally, CMS could explore a measure for the use of antipsychotics for patients with dementia

(similar to a recent skilled nursing facility measure). We note that these categories are non-infectious events and many of them, depending on the structure of the measure, could be low frequency.

As an alternative, CMS could consider developing a non-infectious event composite or aggregate measure, similar to the PSI-90. We strongly encourage CMS to work with relevant stakeholders, including hospitalists, on developing any new measures for the HAC Reduction program.

We also encourage CMS to weigh the burden of collecting additional data for new areas against the overall value to the healthcare system of measuring these events. Any move to add measures to a program should be mindful of the burdens associated with data collection and reporting. Many of the items contemplated for the HAC reduction program may also be topics of quality improvement efforts that are already being addressed at the local level, assessed in programs administered by other organizations (such as The Joint Commission), or directly or indirectly measured by other programs in the CMS performance assessment portfolio.

Inpatient Quality Reporting (IQR) Program

Refining the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166) Measure for the FY 2020 Payment Determination and Subsequent Years

CMS proposes to replace the existing HCAHPS Pain Management composite measure questions with the following three new 'Communication About Pain' composite measure questions:

- HP1: During this hospital stay, did you have any pain?
- HP2: During this hospital stay, how often did hospital staff talk with you about how much pain you had?
- HP3: During this hospital stay, how often did hospital staff talk with you about how to treat your pain?

SHM is supportive of this proposed change as it attempts to address some of our concerns around the current HCAHPS pain management questions and their resulting pressures to prescribe opiates. Reframing the questions toward a more objective measure of communication around pain rather than the highly subjective measure of overall pain management is constructive. As intended, this will hopefully help to remove some of the concern among providers that prescribing of opioids has a connection to positively influencing HCAHPS scoring.

SHM appreciates CMS' willingness to make changes based on provider feedback on the HCAHPS pain management questions. In the past, SHM relayed their concerns to CMS on these questions being linked to performance in the Hospital Value-Based Purchasing (HVBP) program. Although designed to evaluate patients' hospital experience, we believe the existing HCAHPS survey pain assessment questions (During this hospital stay, did you need medicine for pain? How often was your pain well controlled? How often did the hospital staff do everything they could to help with your pain?) create a perverse incentive for the overprescribing of opioid medications as a component of "everything" available to physicians to treat pain.

The existing questions in the HCAHPS survey regarding pain do not recognize the difficulties and subtleties impacting decisions around acute (and chronic) pain management during hospitalizations,

which often require multiple assessments and discussions to achieve adequate, yet safe, pain control. As such, the new communication about pain questions are a step in the right direction.

In addition, there are a broad range of interventions for the appropriate management of pain instead of, or in conjunction with, prescribing opiates. Compounding these clinical decisions, many hospitals attribute HCAHPS scores to individual physician or group performance incentives, despite this not being the intended use of HCAHPS. Due to fear of patient dissatisfaction and poor HCAHPS score performance, HCAHPS questions may directly or indirectly influence prescribing practice, as well as contribute to the ongoing opioid crisis. Trends in opioid prescribing practice should be closely monitored, both before and after implementation of the question changes, to see if there is any impact. In the fight against the public health threat of the opioid epidemic, any possible contributing factors should be closely monitored and quickly acted upon.

We urge CMS to continue evaluating the impact these new 'Communication About Pain' questions may have on HCAHPS scoring and resulting prescribing habits, including collecting more data for the measure as stated in the proposed rule. Even though communication around pain is emphasized in the revised questions, the nuances separating the new and old questions may not translate to all patients. There may be a sizable patient population that continues to associate these questions and responses with an expectation of complete pain control. These new 'Communication About Pain' questions should be carefully monitored for other unexpected and unintended consequences that may arise, including patient expectations and the impact on the doctor-patient relationship. If the proposal is implemented, we strongly encourage CMS to continue working with SHM and other stakeholders to identify and address any problems that may arise.

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 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

[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.

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 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,

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[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.

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 responding 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.

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 Inpatient Prospective Payment System 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 at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

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