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Transforming patient care.

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September 13, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure,

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 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medicare Review Requirements (CMS-1751-P).*

Hospitalists are physicians whose professional focus is the general medical care of hospitalized patients. They provide care to millions of Medicare beneficiaries each year and have served their communities heroically, caring for hospitalized patients throughout the deadly COVID-19 pandemic. In addition to managing clinical patient care, hospitalists also work 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. It is from these perspectives that we offer our comments on this proposed rule.

Calculation of CY 2022 Physician Fee Schedule (PFS) Conversion Factor; Budget Neutrality in the PFS

The proposed rule indicated the PFS conversion factor includes an approximate 3.7 percent payment cut across the entire PFS. SHM is concerned that these payment cuts, coupled with the financial challenges related to the on-going COVID-19 pandemic, will have a profoundly negative impact on hospital medicine finances and patient care quality. We urge CMS to work with Congress to mitigate the impact of PFS cuts required for budget neutrality. Mitigating these cuts is crucial, as the pandemic creates continued uncertainty for the stability and sustainability of many aspects of the healthcare system.

Significant cuts to Medicare reimbursement also risk demoralizing healthcare workers who face unprecedented rates of burnout and exhaustion. Hospitalists in many parts of the country are reporting current COVID-19 surges are as bad or worse than previous highs in 2020. Throughout the last year, many hospitalist groups instituted changes to their staffing and operations to adapt to challenging economic circumstances. Today, staffing shortages are commonplace across the country, with a dearth of physicians and nurses. These shortages impede the ability for our healthcare workforce to combat the COVID-19 pandemic and increase the difficulty faced by non-COVID patients to also receive care. The budget neutrality adjustment to the Physician Fee Schedule will add undue pressure to an already untenable financial situation and exacerbate already existing staffing shortages nationwide.

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. The expansion of telehealth has helped to protect hospitalists and patients by minimizing transmission of COVID-19 in the hospital setting and has expanded the capacity and reach of hospitals and hospital medicine groups. Furthermore, the increased payment rates for telehealth services helped mitigate financial hardship resulting from the dramatic shifts in in-person patient volumes and healthcare utilization. Hospitalists thank CMS for the flexibilities to date and we are pleased to offer our comments on the telehealth proposals for CY 2022.

Revised Timeframe for Consideration of Services Added to the Telehealth List on a Temporary Basis

Hospitalists and hospital medicine groups welcomed the rapid expansion of telehealth services because of the COVID-19 pandemic. Telehealth has been a valuable tool in delivering high quality care while protecting both patients and their providers. To ensure providers have a pathway for continued flexibility around approved telehealth services, **SHM supports the proposal to retain services added to Category 3 until the end of CY 2023 and urges CMS to finalize the proposed timeframe**. This proposal adds certainty over what telehealth services are authorized and reimbursable and, crucially, gives more time for groups to collect data and experience on the value and impact of using telehealth for certain services. We believe this additional time for gathering requisite data will help CMS' future decision making on what services are appropriate to add to the Medicare telehealth services list on a permanent Category 1 or 2 basis.

In this proposal, CMS asks for feedback on what other services should be included as Category 3 that were not added last year. We continue to believe that any service expanded for telehealth in the PHE should be added to Category 3 to give more time with the applicable codes to better inform whether they are appropriate for permanent inclusion on the Medicare telehealth list. **Specifically, we ask CMS to add inpatient admission (99221-99223) and observation (99218-99220) and inpatient/observation admit and discharge same day (99234-99236) to Category 3**. While these services are not delivered via telehealth universally across all hospital settings, the addition of these services has been extremely

important in rural and underserved hospitals. Rural hospitals with fewer resources and staff utilize telehealth admissions, particularly for night coverage, to stretch their limited resources and ensure all beneficiaries receive the care they need and deserve. SHM recommends adding these services to Category 3 so all beneficiaries, including those in rural areas, have access to high quality medical care.

Comment Solicitation for Impact of Infectious Disease on Codes and Rate Setting

The COVID-19 pandemic has created additional and unexpected costs for hospitalists and hospital medicine teams due to the necessity of additional supplies and services demanded by the PHE. Given the lessons learned during the COVID-19 public health emergency (PHE) and other infectious disease outbreaks, CMS should establish a permanent "outbreak activation" policy that would ensure fair and reasonable payment to health care providers when future infectious disease outbreaks occur.

A report from the National Academies of Sciences, Engineering, and Medicine, *Global Health and the Future Role of the United States*, explains that:

In the last 13 years alone, the world has seen many infectious disease outbreaks—such as sudden acute respiratory syndrome (SARS), influenza A virus subtype H1N1, Middle East respiratory syndrome coronavirus (MERS-CoV), Ebola, and Zika virus—all of which presented serious risks to the health security of countries around the world. Yet when such public health emergencies occur, funds to combat them are released in a sporadic and disjointed manner, in amounts far greater than would have been needed for prevention and preparedness.[1]

Despite being under-resourced, health care providers have managed and are currently managing the COVID-19 pandemic. Policymakers have attempted to address this resource challenge through various piecemeal payment enhancements, discussed below.

- As required by the Coronavirus Aid, Relief, and Economic Security Act ("the *CARES Act*"), the U.S. Department of Health and Human Services (HHS) established the *CARES Act* Provider Relief Fund. This fund provided financial support for "healthcare-related expenses or lost revenue due to COVID-19,"[2] through general and targeted distributions to "hospitals and healthcare providers on the front lines of the coronavirus response."[3]
- Through its Hospital Inpatient Prospective Payment System (IPPS), CMS implemented a temporary payment policy to increase reimbursement for hospitals treating patients with COVID-19. Specifically, Section 3710 of the *CARES Act* directed the Secretary to increase the weighting factor of the assigned Diagnosis-Related Group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the COVID-19 PHE. In addition, as part of the IPPS, CMS created a temporary hospital new technology add-on payment for new COVID-19

[1] https://www.ncbi.nlm.nih.gov/books/NBK458470/
[2] https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html
[3] https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html

treatments to ensure access to these treatments is not threatened by MS-DRG payment rates that do not account for these new costs. CMS recently proposed extending this add-on payment through the end of the fiscal year in which the PHE ends.

While these important policies addressed some financial challenges facing certain health care providers, no policy has been implemented to account for the increased level of physician effort and expense associated with delivering care to patients during the COVID-19 public health emergency (PHE). Moreover, the aforementioned policies were not predictable, are temporary in nature, and are specific to the COVID-19 outbreak.

A clinician-focused "outbreak activation" policy would direct resources to *clinicians* that are performing patient care services that require enhanced direct and indirect work to effectively manage an influx of qualifying patients and to perform additional, critical activities associated with managing a pandemic.

As we have outlined in previous comments and in meetings with CMS staff, hospitalists perform tasks associated with treating pandemic patients that are not captured in the Fee Schedule. A list of activities hospitalists perform in concert with their Infectious Disease and Emergency Medicine colleagues, are as follows:

- Donning and doffing personal protective equipment (PPE) and following new infection control protocols
- Expanded cleaning protocols necessitating slower turnaround time on bed space
- Educating, engaging, and enrolling patients in research and investigational initiatives, including clinical trials, expanded access programs (EAPs), and compassionate use (CU)
- Follow-up for persons under investigation
- Monitoring the flow of new research and information, and triaging education to effectively manage the pandemic
- Studying constantly changing treatment and management protocols
- Reconciling and adjudicating incongruous or conflicting findings such as understanding asymptomatic transmission during a pandemic
- Supervising other physician specialties deployed to assist in the care of outbreak patients
- Leading, managing, and advising groups of staff dedicated to evaluating, implementing, and interpreting testing platforms, exposure management, PPE procurement, and associated activities during a pandemic, including contingency functioning related to supplies staff and limited physical capacity
- Daily contingency planning related to hospital capacity and supply availability
- Setting up and operating remote locations such as tents and triage areas
- Creating and managing protocols for isolation of infected or exposed patients and staff
- Crafting visitor and staffing policies
- Providing emotional support for staff
- Planning to safely resume elective procedures, including developing protocols for distancing, testing, sanitation, hygiene and availability and distribution of personal protective equipment

- Collaborating with state and local health departments on public messaging to reduce transmission
- Providing advice and preparing alternative housing for providers isolating from their families
- Capturing and reporting outbreak related data

Modifier as Means to Capture Infectious Disease Outbreak Activities

We believe that creating a modifier hospitalists and other types of providers could append to current E/M codes will provide a unique solution to ensuring that resources are available for care delivered during circumstances of heightened work. The use of a modifier would provide CMS with two useful safeguards (1) CMS could set documentation requirements regarding the existence of the outbreak (e.g., parameters associated with the timeframe that public health officials have declared an infectious disease/public health emergency or reporting associated diagnosis codes); and (2) CMS could set documentation requirements to justify the enhanced services that were provided during the outbreak (e.g., evidence in the medical record that one or more of the aforementioned activities were delivered or influenced care).

We recognize the MPFS is not designed to reimburse clinicians for the precise resources dedicated to an individual case, but rather for the "typical" case; however, during an infectious disease outbreak (which could be national, regional, or local), the patients being served no longer represent the "typical" case. As we have observed during the COVID-19 outbreak, it is these atypical cases that fill the patient rolls, making it difficult to rationalize reimbursing them as "typical" patients. We believe the establishment of a modifier provides CMS with the opportunity to set documentation requirements to ensure that the existence of the outbreak is verifiable and that the "typical" work is performed relative to the "atypical" patient on whom the claim is submitted.

Mechanisms like the temporary inpatient DRG enhancement for positive COVID-19 cases remain valuable for hospitals reimbursed under the Inpatient Prospective Payment System (IPPS), but do not capture, nor reimburse for, the heightened work of physicians and their care teams during an infectious disease outbreak. We believe it is in everyone's interest that CMS implement a policy that addresses these spikes in care that can occur across an entire community in a way that considers the different infectious diseases that will be involved in different outbreaks. A modifier will allow the Agency to more narrowly tailor resource distribution and support program integrity because it would be based on cases where enhanced care is actually being delivered. Additionally, a payment modifier would ensure that physicians, regardless of specialty designation, receive reimbursement commensurate with the atypical activities associated with treating patients during an outbreak or pandemic.

We encourage CMS to implement a permanent mechanism to reimburse clinicians for critical activities associated with managing infectious disease outbreaks. Under our proposal, CMS would automatically initiate payment to clinicians (e.g., under the Physician Fee Schedule) for services associated with these unanticipated events, within certain parameters, when they occur. Such a policy would promote

certainty for both physicians and CMS; physicians could anticipate receiving additional resources, while CMS would have an established pathway for channeling of those resources.

While the CPT Editorial Panel did create a CPT® code 99072 to account for the additional supplies, materials, and clinical staff time during a PHE to capture the items that are above and beyond and atypical of routine office visit E/M, it does not capture the myriad of activities and tasks that are required of hospitalists and other types of physicians during a pandemic. Currently this code is considered bundled and not separately payable under the MPFS. Even if the Agency were to assign a value to this code, it still would not meet the needs of the physician community as it would not account for specific services provided during a pandemic.

Evaluation and Management (E/M) Visits: Split (or Shared) Visits

CMS proposes to define a split (or shared) visit as an "E/M visit in the facility setting that is performed in part by both a physician and an NPP who are in the same group, in accordance with applicable laws and regulations." They also propose to allow physicians and NPPs to bill for split (or shared) visits for new and established patients, initial and subsequent visits, critical care services, and skilled nursing facility E/M visits. Additionally, CMS proposes a definition of "substantive portion [of the visit]" to determine which clinician can bill for the visit. They propose that the practitioner who sees the patient for more than half of the total distinct, qualifying time would be eligible to bill for the visit. **SHM strongly opposes finalizing this proposal for split (or shared) visits.**

CMS asserts that changes in the practice of medicine and, in particular, the evolution of team-based care necessitates clearer definitions and guidelines for split (or shared) visits in facility settings. SHM agrees that physician-led team-based care is a highly prevalent method of providing high-quality care for hospitalized patients today and that Nurse Practitioners (NPs) and Physician Assistants (PAs) are crucial members of this team. However, the proposal, as written, will negatively change existing oversight systems and dynamics among physician and NPP teams. We also agree that it is important for a billing physician to have more than a token, or "sticking their head in the room," encounter with patients. However, we believe that split/shared visits may appropriately include many non-patient-facing activities in which physicians lend their expertise and experience to the care of a given patient. These activities may include speaking with hospital staff such as case managers, other physician consultants, and of course patients and families themselves, who, despite excellent care and communication from an NPP, may insist on "seeing the doctor." Appropriate physician involvement and leadership of the care team need not be patient-facing.

SHM has significant concerns regarding the administrative and logistical burden of this proposal. This will predictably create excessive reporting burdens and divert resources, time, and energy away from direct patient care. Hospital inpatient stays typically last for several days, meaning there may be several E/M visits associated with a patient's stay. The billing provider would need to be adjudicated each time a billable visit is performed and could potentially shift back and forth between clinicians. Each day, two clinicians (a physician and an NPP) would track the time associated their own visit, later in the day comparing notes, and then deciding who will bill. This proposed policy, particularly use of time and the definition of "substantive portion," would require extensive new tracking and quantifying capabilities

and upend longstanding billing practices. Additionally, tracking time spent on each visit is not reflective of how care is typically delivered in the inpatient hospital setting. Care is often non-continuous and fluid, rather than "one patient at a time," making time-based tracking not only difficult, but also a significant distraction that could lead to patient harm, just as all distractions can.

The proposed rule suggests that because discharges are billed based upon time, there is a precedent for time-based billing as proposed for split/share visits. This suggestion ignores the unprecedented complexities of two clinicians having to compare time spent for each visit (and related activities throughout the day) and decide which earned the "substantive portion." for each patient seen that day as a split/share visit.

We also point out how the proposal could run contrary to vicarious liability law as it is generally written today. Physicians who are involved in the care of a given patient assume vicarious liability, regardless of whether any hospital visits were billed in their name. Although state laws vary in terms of how independently NPP's may practice, in general, NPP's practicing in hospitals require close physician supervision. This proposal would mean that both NPP's and physicians would remain liable (as they are today), but the physician would only be reimbursed for their portion of the visit if they provided the "substantive portion" of the visit. Furthermore, there is no mechanism that accounts for this in the Malpractice Expense component of the CPTs used by physicians and APPs for typical hospital split-share visits.

SHM has long-championed efforts to advance team-based care and understands the immense value that interdisciplinary teams bring to the care of hospitalized patients. We believe CMS' proposal for split (or shared) billing will be significantly disruptive to established relationships and present unique operational challenges for hospitals and hospital medicine groups to implement.

Claim Identification
CMS is proposing to create a modifier to describe split (or shared) visits and proposing to require the modifier must be appended to claims for split (or shared) visits, whether the physician or NPP bills for the visit. Currently, CMS cannot identify through claims that a visit was performed as a split (or shared) visit, which means they would know that a visit was performed as a split (or shared) visit only through medical record review.

SHM urges CMS not to require a modifier to be reported for split (or shared) visits. Requiring a modifier adds a level of administrative burden the new E/M coding structure and guidelines were designed to alleviate. We also urge CMS to work with the AMA CPT/RUC Workgroup on E/M to create a proposal to the CPT Editorial Panel to address this question and to clarify the reporting in CPT Guidelines. It is important physicians can focus on one consistent set of guidelines in reporting their services.

Evaluation and Management (E/M) Visits: Critical Care

CMS proposes to adopt the CPT guidelines for the reporting of critical care services. However, in their proposal, CMS also proposes physicians would no longer be able to report other Evaluation and

Management (E/M) Services on the same date as a critical care visit. This is contrary to CPT specific instructions (CPT 2021 Professional, page 31) that state "[c]ritical care and other E/M may be provided on the same patient on the same date by the same individual." We urge CMS to reconsider this proposal, as the billing for E/M services and critical care services on the same day reflects the reality of patient care. It is common that patients who are initially hospitalized do not require critical care services at the time of admission but later require critical care services on the same day. **These are separate services and should be reported and paid.**

Critical Care Visits and Global Surgery

CMS is also proposing to bundle critical care visits with procedure codes that have a global surgical period. **SHM strongly disagrees with this proposal.** This change would predictably lead to reduced access to critical care services for patients who require routine critical care (such as post- coronary bypass patients) and for patients who have undergone other elective procedures (covered by a non-zero-day global period) and suffered a life-threatening complication, requiring critical care. SHM agrees that, for surgeons already being compensated under a global period, there are circumstances in which additional critical care services billed outside of the global fee may be duplicative and should be included in the reimbursement of the global fee. For example, when a patient is having a normal, favorable post-operative recovery that is typical for a given surgery, additional critical care billing by the surgeon or a member of their team would appear to be outside the purpose of a global fee. However, when patients have adverse events following elective surgeries, including those that have a non-zero-day global period, they may require access to critical care services that may be provided by hospitalists, critical care, or other specialists. **SHM strongly urges CMS to retain the ability for clinicians who are not included in the global fee to continue to be reimbursed for the critical care services they often provide for these patients.**

CY 2022 Updates to the Quality Payment Program

Closing the Health Equity Gap in CMS Clinician Quality Programs—Request for Information

Throughout the United States, minority groups experience persistent health care inequities and disparities, including within the Medicare beneficiary population. SHM lauds CMS for its commitment to remedying health inequities and achieving equitable health outcomes.

Future Stratification of Quality Measure Results by Race and Ethnicity

CMS' existing disparities methods use Medicare and Medicaid dual eligibility as a proxy of social risk and indicator of risk of poor health outcomes. To provide a more holistic view of health care outcomes, CMS is considering using indirect estimates of race and ethnicity to stratify quality measures. While we agree with the necessity of doing more to quantify and illuminate health disparities, we are concerned about the use of indirect imputation. Indirect estimates of race are likely to be inaccurate, particularly for multiracial and indigenous persons. Furthermore, stratifying measures using estimates may inadvertently exaggerate or disguise disparate outcomes. While imputed estimation may be feasible, we

caution CMS that no algorithm is wholly neutral or objective; assumptions, biases, and generalizations underpin algorithms, and we are concerned how those assumptions could impact the quality and validity of the data it will produce. As CMS notes, indirect estimated data has typically been used at the population level, not at the individual clinician or group level.

Furthermore, only accounting for race and ethnicity fails to capture the complete range of social factors that impact health, including language barriers, socioeconomic status, or zip code. Social determinants are important indicators of health, whereas analyzing inequities using race and ethnicity alone provide a less holistic portrayal of factors that impact health. Furthermore, if CMS moves forward with stratified measures using these estimated algorithms, CMS must ensure that stratified measures do not inadvertently deepen inequities.

We applaud CMS' efforts to address disparities and encourage CMS to be cautious when implementing methodologies. If CMS decides to move forward with their proposed expansion, we believe feedback to providers should remain informational. We also ask that CMS provide resources and support to help clinicians interpret and understand any stratified data provided to them.

Improving Demographic Data Collection

CMS seeks feedback on hospitals and clinicians collecting information such as race, ethnicity, gender identity, and other demographic information at the time of admission. They propose collecting standardized demographic information so the data can be used to identify existing inequities. In theory and concept, we understand demographic data can be used as a tool to highlight and combat inequities. In practice, however, providers face significant challenges collecting data related to race, ethnicity, sexuality, and gender.

Collecting demographics data can be challenging and resource intensive, with hospitals relying on both intake staff and digital resources. The existing healthcare software also poses challenges in collecting demographics data and would require significant time and resources to ensure demographics are being collected consistently across the country. Marginalized patients may also have legitimate concerns that self-disclosing demographic information like sexuality, gender identity, or tribal affiliation will negatively impact their care. As a result, patients may decline to self-identify, creating further challenges when collecting demographic information at the time of admission. We raise this concern to note that even self-reported data may have its own biases and may not accurately capture the range of experiences or risks faced by a population. While we are supportive of identifying and studying metrics to reduce disparities, it is important that the requisite data collection does not create overly excessive reporting burdens or concern from patients.

We strongly encourage CMS to identify and utilize resources that currently exist to track race and ethnicity data. Many community-level indices, like the Community Needs Index (CNI), collect demographic data. Rather than creating additional and excessive reporting burdens, CMS may find this information is already collected and recorded. Using existing indices will ensure CMS and hospitals have

access to information to address health outcomes disparities without creating new administrative and reporting burdens.

Transforming MIPS: MIPS Value Pathways

CMS has stated an intention to move MIPS reporting to MIPS Value Pathways (MVPs) to reduce the burden of program participation and streamline movement towards alternative payment models (APMs). The MVP combines measures and activities across all four categories of the MIPS for a specialty, medical condition, or episode of care. SHM has long supported the concept of simplifying quality reporting and pay for performance programmatic requirements and believes that creating more opportunities and accessibility for APM participation is needed to transform the healthcare system.

In our comments over the last two years, we voiced concern that the MVP concept was not meaningfully differentiated from traditional MIPS reporting. With the proposals for CYs 2022 and 2023, we continue to believe the MVP structure does not represent a significant shift away from basic MIPS reporting. However, we do recognize CMS' statutory limitations on altering the program without Congressional intervention. We are appreciative of CMS' MVP proposals that reduce reporting requirements, such as the number of quality measures, and encourage CMS to continue to look for ways to separate MVPs from traditional MIPS reporting.

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 clinician. 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.

We continue to urge CMS to keep MVPs as an optional pathway for participation in the MIPS for the foreseeable future. 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.

MVP Implementation Timeline

CMS proposes to enable MVP reporting for the 2023 MIPS performance period (2025 MIPS payment year) and keep MVP reporting voluntary until the 2027 performance period. CMS is also considering making MVP reporting mandatory beginning in the 2028 performance period.

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SHM agrees with the proposal to delay implementation of MVP reporting until the 2023 performance year as we believe MIPS eligible clinicians and groups need additional time to understand this transition. This delay also gives CMS and healthcare stakeholders more time to develop and refine the operational aspects of the MVP and develop new MVPs for the program. We also appreciate that CMS stated their intention to consider making MVPs mandatory in the 2028 MIPS performance period but caution against making formal proposals to this effect. We acknowledge that there is ample time for MVP development between now and 2028. However, we are concerned that MVP development will mirror the slow pace of measure development across the MIPS program, particularly for specialties like hospital medicine that have a dearth of relevant measures. We urge the agency to work proactively with specialty societies and other stakeholders to help develop MVPs relevant to their clinicians, ensuring all providers can meaningfully participate in the MVPs. **We urge CMS to keep MVP reporting voluntary and refrain from formally sunsetting traditional MIPS reporting until the Agency can ensure that <u>all</u> MIPS eligible clinicians and groups have applicable MVPs in which they can participate.**

General Comments about Subgroups

CMS is proposing a methodology for subgroup reporting. They propose a subsection of clinicians within a Taxpayer Identification Number (TIN) would be able to report on a different MVP than other clinicians in that TIN. We understand that subgroup reporting, at least conceptually, enables more relevant and applicable measurement of clinicians. However, we believe subgroup reporting will add a significant amount of administrative complexity and burden for groups participating in the MIPS. It creates new expectations for granular reporting within the MIPS and requires substantial new investments in reporting capability across specialty and service lines. Although some groups may have this capacity through their existing systems, we believe this proposal will be challenging for under-resourced programs, such as rural and urban hospitalist programs and those that have multispecialty groups. MIPS reporting requires a significant investment in time, resources, staffing and/or expense toward external vendors and contractors for successful participation. In addition, many hospital medicine groups who score well in the MIPS have indicated the positive payment adjustments do not exceed the costs for their participation. Subgroup reporting adds new layers of group reporting and will require additional resources for success. Much like concerns about the overall MIPS program, SHM believes subgroup reporting will reinforce and add to existing challenges and resource issues for many groups within the program, particularly those in rural or under-resourced areas.

Subgroup Implementation Timeline

CMS proposes to allow subgroup reporting in the 2023 performance period, paired with implementation of MVPs. They also propose to no longer allow multispecialty reporting for MVPs in the 2025 MIPS performance period and would instead require these groups to form subgroups to report MVPs. **SHM is opposed to both aspects of this implementation timeline for subgroups and urges CMS to work out more of the operational details prior to finalizing this reporting structure.**

We are also opposed to CMS' proposal to make subgroup reporting mandatory for multispecialty groups in MVPs and believe subgroup reporting should remain voluntary. CMS states that subgroup reporting is intended to address a dynamic in MIPS reporting wherein multispecialty groups are reporting on measures that do not reflect the care provided by all the specialties of clinicians within the group. While we do acknowledge this aspect of multispecialty group reporting, we believe the proposed subgroup reporting creates new and additional burdens within the MIPS program and may serve as an impediment to team-based care.

Subgroup Composition and Limiting Subgroup to Single Specialty

CMS proposes definitions for single specialty and multispecialty groups that rely on the specialty type of providers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). We have serious reservations about the definition of single specialty and multispecialty group that relies on PECOS identification. Hospitalists are physicians who practice in acute care hospitals and are most commonly trained in internal medicine or family medicine. Until 2017, Medicare did not have any unique identifier for hospitalists in PECOS; they were registered under their parent specialty. In 2018 Medicare provider utilization data (most recent data available), there are 11,296 unique NPIs registered as hospitalists (C6 in the Medicare specialty codes). SHM estimates that there may be more than 40,000 practicing hospitalists around the country, meaning most hospitalists are still identified as internal medicine or family medicine in PECOS. We also note that team-based care increasingly means interdisciplinary care, where clinicians from different specialties or professional training are working together to care for the unique needs of each patient. A common hospital medicine team may have clinicians who are identified as hospitalist, internal medicine, family medicine, nurse practitioner, and physician assistant. CMS' proposed approach would fragment these teams and disrupt existing cross-specialty relationships. **We do not recommend finalizing these definitions**.

CMS asks for feedback on whether a threshold, such as 75 percent of clinicians with the same specialty, should be established for a subgroup to be considered a single-specialty subgroup. They suggest aligning this policy with other existing thresholds in the MIPS program (such as hospital-based or facility-based). We do not believe this threshold would account for the variety of clinicians involved in hospital medicine and how they are registered/enrolled with Medicare. **We do not support a 75 percent single specialty threshold.** Unlike the other thresholds in the MIPS which are more closely tied to services performed, using specialty designations in PECOS would not serve as an appropriate proxy for whether a set of clinicians in a group are performing similar or the same work.

For the reasons listed above, we also encourage CMS not to limit subgroup composition to single specialty. We believe as hospitals and health systems work towards more coordinated care, policies that silo clinicians by specialty will become impediments to streamlined care teams.

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MVP Requirements: Population Health Measures

In the foundational layer of every MVP, CMS has a requirement for a population health measure. There are two population health measures—the previously finalized *Hospital-Wide, 30-Day All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Eligible Clinician Groups* Measure and the proposed *Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions*. SHM continues to have concern about the use of the HWR Measure in the MIPS program, as published literature and hospitalists' experience indicates that the window for hospitals or clinicians to influence readmission rates is much smaller - potentially as small as 7 days - than the 30-day window in the measure. Given the level of measurement of the MIPS program is the individual clinician or group, CMS' population health measures for MVPs should be measuring activities and outcomes that are appropriately attributable to these providers. We ask CMS to take this criterion into account as they are evaluating population health measures for MVPs.

Proposed MVP Reporting Requirements

CMS proposes reduced reporting requirements for Quality and Improvement Activities in MVPs. Specifically, CMS proposes requiring four quality measures, including one outcome or high priority measure and two medium or one high-weighted improvement activities or participation in a Patient Centered Medical Home. **SHM supports these proposals as a reduction in administrative burden for the program and to enable groups and individual clinicians to focus on a smaller subset of priority measures and activities.**

Subgroup Registration

CMS proposes to create a registration period of April 1- November 30 of the performance year for subgroup participation and to require submitting a list of each TIN/NPI in the subgroup. SHM believes this registration period creates operational challenges for hospital medicine groups, particularly since many hospital medicine groups report annual turnover rates of 10 percent among their physicians. **We encourage CMS to reconsider their alternative registration period that aligns with performance data submission**. This would enable groups to submit data on behalf of the correct list of TIN/NPIs associated with their subgroup. We also note this alternative registration period still enables CMS' proposed enhanced performance feedback for MVPs.

MVP Scoring: Facility Based Scoring

CMS proposes to continue calculating a facility-based score for any eligible MVP participant and use the highest final score for the purposes of the MIPS final score. **SHM supports this policy as a continuation of existing policies for traditional MIPS reporting.**

Comments about Facility Based Scoring and COVID-19

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For the 2021 MIPS Performance Year, CMS indicated that facility-based scoring will be unavailable to MIPS eligible clinicians and groups. This is because CMS' policies in the Hospital Value Based Purchasing program to adapt to COVID-19 disruptions will leave hospitals without a Total Performance Score (TPS), making the MIPS facility-based scoring option unavailable. Individual clinicians and groups who typically participate in the MIPS through facility-based scoring will need to either report on quality measures separately or apply for an Extreme and Uncontrollable Circumstances Hardship Exception. Looking at the on-going disruptions caused by COVID-19, SHM believes that the 2022 MIPS Performance Year will be similarly affected. **We ask CMS to make the hardship exception automatically applied to any MIPS eligible clinician or group that is eligible for facility-based scoring.** This would be aligned with how the facility-based scoring option is automatically applied. Consistent with existing policies, if an individual or group submits MIPS measures through another methodology, their hardship exception would be overridden.

Request for Information regarding the COVID-19 Vaccination by Clinicians Measure

CMS developed the COVID-19 Vaccination by Clinicians measure as a response to the on-going COVID-19 pandemic. The measure would assess the percentage of patients seen in the measurement period who have ever completed or reported having completed a COVID-19 vaccination series. SHM is a strong proponent of vaccination as our best tool towards controlling the COVID-19 pandemic and preventing morbidity and mortality. We believe that encouraging vaccination is an important goal and that a quality measure can serve as a signal for CMS' prioritization of this topic.

After reviewing the COVID-19 Vaccination by Clinicians measure, SHM identified several potential issues with the measure and believes CMS should continue refining the measure prior to implementation. First, we believe a stronger measure would capture a baseline vaccination rate and assess against that baseline. This would directly encourage outreach for vaccination while also acknowledging the variability of current vaccination rates around the country. As currently structured, the measure may penalize providers who happen to care for a patient population with low vaccination rates. Second, the measure may not be as appropriate for hospitalists and other facility-based clinicians as it is for office-based providers. A complementary measure at the hospital- or health system-level may better reflect the efforts of providers to increase vaccination rates. Finally, we believe CMS should consider how they can incentivize activities that work to increase vaccination rates, not just as a passive assessment of patient vaccination rates. This is particularly germane given that the measure has significant exceptions and exclusions that do not encourage or compel clinicians to address vaccine hesitancy.

We also raise concern about the timeliness of measures needed to respond to urgent or emergent threats like COVID-19 and encourage CMS to consider ways to further accelerate reactive measure development – even if such reactionary measures are only implemented temporarily. We also encourage CMS to consider developing measures for other vaccines that are available to the general

public as vaccine hesitancy and misinformation is a major public health issue that goes beyond the COVID-19 vaccines.

Redistributing Performance Category Weight for Facility-Based Measurement

CMS proposes a new policy for how final scores are determined for clinicians and groups that are eligible for facility-based measurement. The proposal is to score the MIPS quality and cost category scores based on facility-based measurement scoring unless a clinician or group receives a higher MIPS final score through another MIPS submission. This seeks to account for circumstances when a facility-based eligible clinician or group would have otherwise had the weight of the Cost category redistributed outside of facility-based scoring. **SHM supports this proposal as it aligns with other MIPS scoring policies that assign the highest possible score for clinicians and groups with multiple MIPS scores.**

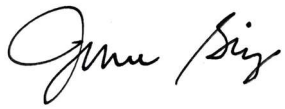
Establishing the Performance Threshold

CMS proposes to set the performance threshold at 75 points for the 2024 MIPS payment year, which is the rounded mean final score from the 2019 performance period. CMS is required by statute to set the Performance Threshold at either the mean or median of a previous performance period. We appreciate CMS' continued stepwise approach to setting the performance threshold and agree with the rationale to not commit to a larger jump in the performance threshold than was used for the past three years. Looking ahead to future years, SHM is concerned that a very high mean or median will emerge and therefore tiny differences in overall performance will lead to divergent payment adjustments between practices. This mirrors our experience with topped-out or nearly topped out measures where small variances in performance yield major differences in scoring. We encourage CMS to work with stakeholders and with Congress to address potential future issues with the performance threshold and the MIPS' overall value to the healthcare system.

Conclusion

SHM appreciates the opportunity to provide comments on the FY 2022 Physician Fee Schedule proposed rule and looks forward to continuing to work with the agency on these policies. If you have any questions or require more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org.

Sincerely,



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