

APPENDIX – Society of Hospital Medicine

The Society of Hospital Medicine (SHM), on behalf of the nation’s nearly 57,000 hospitalists, appreciates the opportunity to provide feedback on the Ways and Means Health Subcommittee’s Provider Statutory & Regulatory Relief Initiative.

Hospitalists are front-line healthcare providers in America’s hospitals for millions of hospitalized patients each year, many of whom are Medicare and Medicaid beneficiaries. As leaders of an interdisciplinary care team, they manage the inpatient medical needs of their patients, while working to enhance the performance of their hospitals and health systems. Although most hospitalists are Board Certified in Internal Medicine or Family Medicine, they practice exclusively in facility settings and do not have outpatient office practices. Hospital medicine practitioners have a variety of employment structures, ranging from direct employment by a hospital or health system to independent staffing groups that contract with a hospital. In these varied roles, hospitalists have front line perspectives on policies that improve health care and those that stand in the way.

ISSUE 1 – Elimination of Observation Status

Observation is an outpatient designation originally intended to give providers time to decide whether a patient needs to be admitted as a hospital inpatient or discharged back to the community. This decision should be based on the patient’s condition and the provider’s clinical judgment as to the best course of action for a patient’s care. Outpatient observation services are not defined in statute or regulation, but are only defined in the Medicare Benefit Policy Manual¹.

However, the intricacies of observation policy have created a situation where observation care is now commonly being delivered on hospital wards, indistinguishable from inpatient care. The frequency and duration of observation status has also grown significantly in recent years, well beyond its original intent. This is important because observation is not covered by Medicare Part A hospital insurance, leaving patients liable for more variable copays and coinsurance under Medicare Part B. At the same time, hospitals may be reimbursed at lower rates for observation care even as the services and staffing required are nearly identical to inpatient care.

Current observation policy is a clear barrier to delivering “the right care in the right setting at the right time”. Medicare does not cover a skilled nursing facility (SNF) stay unless the beneficiary has been admitted to the hospital as an inpatient for at least 3 days². This leaves patients under observation ineligible for SNF coverage at discharge, which may leave them vulnerable to additional and higher out-of-pocket expenses. Many Medicare beneficiaries present to the hospital for minor complications associated with chronic conditions and do not necessarily require care at hospital level intensity, but would benefit greatly from a higher level of care than what is available in the community setting, such as

¹ Medicare Benefit Policy Manual. CMS Pub. 100-02. Chap. 6 Sec. 20.6 (Rev. 215, Dec. 18, 2015)

² Medicare Benefit Policy Manual. CMS Pub. 100-02. Chap. 8 Sec. 20.1 (Rev. 228, Oct. 18, 2016).

a skilled nursing facility (SNF). This seemingly arbitrary requirement causes numerous obstacles for patients who end up being placed under observation status and for providers who know the patient cannot be safely sent home, but for coverage purposes, does not qualify for needed care at a step-down facility. If a beneficiary would clearly benefit from post-acute care after their hospital stay, but does not meet the 3-day inpatient requirement, they will often forego or truncate recommended SNF care to avoid paying out-of-pocket fees. This foregone care can lead to otherwise preventable complications (i.e. dehydration, falls, etc.), degradation of health status, and a readmission to the hospital – which drives up readmission rates and has serious financial implications for both patients and Medicare.

Providers, hospitals, and their patients are feeling unnecessary pressures from observation policy, which continues to siphon valuable resources away from direct patient care and move them towards bureaucratic tasks unrelated to patient care.

Hospitalists are central players in the inpatient admission decision. They also provide the majority of observation care to patients (59% of all Medicare hospital observation care in 2012 was provided by hospitalists)³. They are commonly the admitting physician affected by status determinations and are primary points of contact helping patients navigate the consequences of being placed on observation. Both the Centers for Medicare and Medicaid Services (CMS) and Congress have taken steps to address observation care. These included the 2-midnight rule, which was an attempt to simplify admission decisions, and the Notification of Observation Treatment and Implication of Care Eligibility (NOTICE) Act, which aimed to provide more transparency for patients who are under observation. Despite these efforts, observation remains a significant problem and the following concerns continue:

- Lack of clear observation rules for hospitalists
- Waste of healthcare dollars to maintain a policy that does not improve patient care
- Impaired physician-patient relationship
- Remains an important policy issue for hospitalists and inpatient providers

These concerns make it clear that the current use of hospital observation status remains problematic, even after the implementation of the 2-midnight rule and the NOTICE Act. We believe this creates a significant opportunity for the House Ways and Means Committee's Provider Statutory & Regulatory Relief Initiative.

Policy Recommendations

SHM believes the House Ways and Means Committee could take multiple approaches toward addressing challenges associated with observation care. While we prefer a comprehensive approach (Options 2, 3, or 4) that would tackle all our concerns, we acknowledge the committee may wish to prioritize its efforts. Therefore, we offer potential options below:

1. Legislative: Improve access to Medicare Skilled Nursing Facility (SNF) Coverage

³ Source: analysis by Society of Hospital Medicine, using hospitalist identification outlined in Lapps, *et al.* Updating threshold-based identification of hospitalists in 2012 Medicare pay data. *J of Hospital Medicine*. September 18, 2015. Accessed: <http://onlinelibrary.wiley.com/doi/10.1002/jhm.2480/abstract>.

Goal: Access to SNF coverage for patients is a major concern for hospitalists. We encourage policy changes that disentangle sub-acute rehabilitation service eligibility from inpatient utilization and eliminate the requirement for 3 midnights to qualify for SNF payment. Trust the provider to place patients in the care setting they need in the timeframe they need it. It is counterproductive to require a patient to be in the hospital and meeting an arbitrary length of stay threshold before they can be transferred to an appropriate care facility. If a patient is able to be appropriately transferred to a SNF early in their hospital stay, the system saves unnecessary financial expenditure and the patient is able to receive the appropriate level of care - overall patient care is improved at a lower cost.

As a starting point, the Committee can look to the *Improving Access to Medicare Coverage Act of 2017* which would allow all Medicare beneficiaries access to SNF care after three hospital midnights, regardless of whether those midnights are inpatient or observation. This legislation could be used as a model to design and support legislation that would eliminate the 3-day stay requirement entirely.

Rationale/specifics:

a) New data suggests that prior cost concerns over expanded SNF access may be unfounded:

- MedPAC's June 2015 Report to Congress, Pages 189-190: If all 3 midnight stays qualified for SNF stay, this would generate about 20,000 more SNF stays. At a rate of \$10,500 per stay, that is about \$200 million dollars.⁴
 - However, the OIG reported that CMS has already paid for 90% of these stays (in error) already, so this cost may already be largely paid by Medicare
- Recent data has suggested that SNF use, and therefore cost, may not change if access is improved:
 - Grebla et al (Health Affairs 2015) found that from 2006-2010, Medicare Advantage Programs with a SNF waiver did not lead to increase SNF use⁵
 - Dummit et al (JAMA 2016) showed via preliminary Bundled Payments for Care Improvement (BPCI) data that cost savings were largely from reduced SNF usage in the post-acute period when payments were bundled⁶

2. Legislative/Regulatory: Eliminate hospital observation altogether with use of a low acuity DRG modifier

⁴ Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2015. Accessed August 23, 2017 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>.

⁵ Grebla, RC, et al. Waiving the Three-Day Rule: Admissions and Length-of-Stay at Hospitals and Skilled Nursing Facilities Did Not Increase. *Health Affairs*. August 2015. 34:8. 1324-1330.

⁶ Dummit, LA, et al. Association between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes. *JAMA*. Sept. 27 2016. 316:12. 1267-78.

Goal: Adopt a “Low-Acuity” DRG modifier for hospitalized patients and return observation to its original intent: an extension of the Emergency Department visit lasting less than 24 hours and taking place inside an observation unit. Draft and pass legislation or work with HHS to create a low-acuity DRG modifier.

Rationale/specifics:

- All patients admitted to the hospital would be admitted as inpatients and would be billed from one of the three current inpatient levels for initial (99221, 99222, 99223) and subsequent (99231, 99232, 99233) care each day, and from one of two current discharge levels (99238, 99239)
- A case manager or coder would retrospectively determine whether a low-acuity modifier should be assigned to this patient’s DRG for this stay, when a patient’s condition and clinical needs are fully known
- DRGs which receive the low-acuity modifier would be reimbursed at a predetermined fraction of what the full inpatient stay would be
- Auditors would assess application of the low acuity modifier
- This would decrease usage of important clinical resources, such as physician time, being applied towards ‘anticipatory guidance’- which is highly subjective and not evidence based

3. Regulatory: Encourage CMS to test eliminating hospital observation with an advanced APM model or bundled payment that would capture the post-acute period/SNF care.

Goal: Similar to a DRG with acuity modification, this option would bundle service needed for an observation stay plus risk extending into the post-acute phase, which would be similar to the clinical condition episode bundled payment (BPCI). Or, could establish a hospital medicine advanced APM with hospitalists getting a per “unit” payment for all the patients they see, with risk extending into the post-acute phase and auditing done to ensure large shifts in practice did not occur (i.e. excessive SNF use). Encourage CMMI to develop models to eliminate observation.

Rationale/specifics:

- Would be most consistent with current trends in payment reform and lessons learned in the Medicare Advantage programs (Grebla, et al. Health Affairs 2015)
- Shared savings/risk mitigates gaming and encourages collaboration between providers and facilities
- Would enable more providers to access the Advanced APM incentive pathway of MACRA

4. Legislative: Eliminate hospital observation care, making all hospital stays inpatient except for those covered by ED observation units

Goal: Eliminate a flawed policy and consider all hospitalized patients inpatients, while preserving ED observation units. Draft and pass legislation eliminating observation care.

Rationale/specifics:

- Regulatory (i.e. the 2-midnight rule) and legislative (NOTICE Act) solutions have not solved the observation problem, and further policy “tweaks” are unlikely to fix a fundamentally flawed policy
- Budget neutrality could be achieved. For example, Congress could mandate a “blended rate” payment for all hospitalizations, except for those instances covered by ED observation units
- Clinical resources could be diverted from administrative tasks and applied to optimizing care and efficiency during the inpatient stay, at no increase in cost

Despite regulatory and legislative changes, hospital observation care is no better than it was in 2014. Admission status should not be replete with the tensions and challenges described by hospitalists and many others. A payment policy that provokes confusion amongst providers and potentially harms the beneficiary should be scrutinized more critically. Any changes in policy should reflect the reality that observation hospital care is inpatient care, and should be billed as such to Medicare Part A. As inpatients, those once designated as observation would access post-acute care when they need it, and would not be faced with difficult decisions about whether to forgo or shorten requisite services due to cost or arbitrary rules. For hospitals and hospitalists, admission policies should be easy to understand, and reduce impediments to workflow, defer to physician judgment, and decrease administrative burden. Much legislative and regulatory work is needed to achieve these goals.

ISSUE 2 – MACRA’s APM Payment/Patient Thresholds

MACRA established thresholds at 45 U.S.C. 1395l(z)(2) defining qualifying APM participants for the Incentive Payments for Eligible Alternative Payment Models (APMs). In 2019 and 2020, the thresholds are set at 25% of Medicare payments; 2021 and 2022 at 50%; and 2023 and beyond at 75%. Starting in 2021, the payment thresholds may be met through all-payer analyses. Providers may also meet a threshold of Medicare patients, which CMS has promulgated at a slightly lower rate. We understand these thresholds were designed to ensure that providers continue to move significantly away from the fee-for-service (FFS) system, but these thresholds have inserted significant uncertainty.

SHM has serious concerns about the ability of providers to meet thresholds, particularly as they increase in future years. Moving into an APM requires significant investment from providers for appropriate infrastructure (staffing, data analytics), education, and restructuring provider workflow. Based on our member’s experiences in the Bundled Payments for Care Improvement (BPCI) initiative, we believe the thresholds will lock many providers out of moving into the APM track even after making the investment and attempt. Many of the provider-led APMs tend to be disease/condition or specialty specific, meaning the covered revenue or patients are a smaller proportion of the provider’s total practice. By way of example, Hospitalists as a specialty are by far the largest participants in BPCI and we expect them to also be the largest participants in Advanced BPCI when the model becomes available. Despite their aggressive efforts to move away from FFS, we believe that very few hospitalists, if any, will qualify for the APM track under the current payment/patient thresholds.

Another feature of using a threshold-based criterion is a lack of predictability on whether a provider who is participating in an APM will be able to qualify for the MACRA APM track. To qualify for the track, a provider must meet a prescribed threshold, however, changes to their patient population could lead a participant to qualify one year and not the next. This problem becomes exacerbated as the thresholds

increase by law. Uncertainty in this space impedes investment and movement away from FFS Medicare payments.

Hospitalists in particular face several barriers towards participation in an APM. As facility-based providers, most hospitalists have little to no control over whether or not their facility participates in an Advanced APM. Hospitalists are also not in a position to choose their patients and generally have no control over whether a given patient, or services provided in caring for a patient, would or would not count towards Advanced APM payment thresholds. This is compounded by the fact that patients are free to seek care outside of an APM at any time.

SHM recognizes the threshold percentages are mandated by MACRA. CMS is attempting to address this concern by allowing for the counting of patients from not just the provider initiated Advanced APM, but also any additional APM in which that provider is a participant. This approach may help in some instances, but judging APM participation based on thresholds of payments or patients is unrealistic for many providers. While encouraging providers to actively seek APM participation is a laudable goal, participation in additional Advanced APMs that would contribute to meeting thresholds is not possible if there are no additional Advanced APMs available. As such, many providers' QP status is either left to chance and as thresholds increase, leave them completely unable to meet the qualifying patient or payment thresholds.

Solution

We urge the House Ways and Means Committee to consider amending MACRA by adding a section, in addition to the thresholds, that grants the Secretary the flexibility to determine APM participation/qualified provider status via means other than threshold determination. These means could be based on the APM model itself, the types of providers participating in the model or any other appropriate methodology, as determined by the Secretary. Not all models or providers who are participating in models will fit within the one size fits all approach that the payment/patient thresholds establish. We believe this flexibility is necessary, particularly if Congress wishes to encourage increased adoption of provider-led APMs.