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September 6, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1770-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 and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts (CMS-1770-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 them a distinctive role in both individual physician-level and hospital-level performance measurement programs. It is from these perspectives that we offer our comments on this proposed rule.

Payment for Medicare Telehealth Services

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. It has also expanded the capacity and reach of hospitals and hospital medicine groups. Furthermore, parity in payment rates for telehealth services helped mitigate financial hardship resulting from the dramatic shifts in in-person patient volumes and healthcare utilization. Telehealth has also enabled services to reach patients in underserved and remote areas who may not otherwise have access to care.

Expiration of Category 3 Services

SHM welcomed the addition of Category 3 to the Medicare Telehealth Services list, which will keep services available for payment through at least the end of 2023, depending on how long the declaration of a PHE continues. Other services, including inpatient and observation initial visits (99218-99220, 99221-99223) and hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date (99234-99236), which were temporarily added to the Medicare Telehealth Services list during the PHE, will remain reimbursable as telehealth for 151 days after the expiration of the PHE.

We remain strongly supportive of maintaining payment for telehealth services, including many hospital-based services, after the expiration of the PHE. This includes services contained in the Category 3 list and those falling within the 151-day period for those services not added as Category 1, 2, or 3. Telehealth has been a critically important tool during the pandemic, and we believe it will continue to be an increasingly valuable and normalized tool that allows clinicians to deliver high quality medical care more broadly.

We continue to urge CMS to consider adding inpatient and observation initial visit (99218-99220, 99221-99223) and hospital inpatient or observation care for the evaluation and management of a patient including admission and discharge on the same date (99234-99236) to the Medicare Telehealth list as Category 3. While these services are not delivered via telehealth across all hospital settings, the addition of these services has been important in rural and underserved hospitals. Rural hospitals, with fewer resources and often inadequate staffing levels, utilize telehealth admissions, particularly for night coverage, to stretch their limited resources and to ensure all beneficiaries receive the care they need and deserve. We believe that including these services as Category 3 will enable more data to be collected about the use and value of these services when delivered as telehealth. We also ask CMS to make public more data about utilization of telehealth codes to better inform stakeholders about the usage of telemedicine within the Medicare program.

Code Valuation Under the PFS: Evaluation and Management (E/M) Visits

Valuation of Hospital Inpatient or Observation Care Services

CMS proposes to accept the AMA RVS Update Committee (RUC) recommendations for the hospital visit family of Evaluation and Management (E/M) codes (99221-99223, 99231-99236, 99238-99239). The table below shows the proposed changes.

CPT CODE	Current Work RVU	RUC Recommendation	Proposed Work RVU
99221	**1.92**	**1.63**	**1.63**
99222	**2.61**	**2.60**	**2.60**
99223	**3.86**	**3.50**	**3.50**
99231	**0.76**	**1.00**	**1.00**
99232	**1.39**	**1.59**	**1.59**
99233	**2.00**	**2.40**	**2.40**
99234	**2.56**	**2.00**	**2.00**
99235	**3.24**	**3.24**	**3.24**
99236	**4.20**	**4.30**	**4.30**
99238	**1.28**	**1.50**	**1.50**
99239	**1.90**	**2.15**	**2.15**

We are supportive of the proposed values for 99231-99233, 99234-99236, and 99238-99239. **However, we oppose the proposed values for 99221-99223 in light of how this proposal changes the historical relativity of these codes to the other E/M code families**. In particular, the proposed decreases to the three initial visit codes (99221-99223) make significant changes to the historical relativity and relationship between these inpatient codes and the comparable office visit codes. This change severely undervalues the expertise and work required to deliver quality inpatient care.

SHM worked with ACEP and IDSA, two other societies whose members use these codes regularly, to examine the historical relativity for these codes and develop alternative recommendations. We believe historical relativity is an appropriate comparison as it builds on CMS' rationale for the Emergency Department E/M codes articulated in the CY2020 Physician Fee Schedule rule, which emphasized avoiding rank-order anomalies in the E/M families. Our recommendations mirror the historical relationship between the hospital visit and office outpatient codes. The charts below show the shift in relativity between the historical relativity and the proposed values in this rule.

Historical Relativity: 2020 Valuations				
CPT Inpatient	wRVUs	CPT Outpatient	wRVUs	Inpt. cf. Outpt.
99221	1.92	99203	1.42	**35.2%**
99222	2.61	99204	2.43	**7.4%**
99223	3.86	99205	3.17	**21.8%**

Current Relativity: Updated Office Visit Values				
CPT Inpatient	wRVUs	CPT Outpatient	wRVUs	Inpt. cf. Outpt.
99221	1.92	99203	1.60	**20%**
99222	2.61	99204	2.60	**0.4%**
99223	3.86	99205	3.50	**10.3%**

Proposed Relativity: PFS 2023				
CPT Inpatient	wRVUs	CPT Outpatient	wRVUs	Inpt. cf. Outpt.
99221	1.63	99203	1.60	**1.9%**
99222	2.60	99204	2.60	**0.0%**
99223	3.50	99205	3.50	**0.0%**

As the charts illustrate, the historical and current relationship between the three initial hospital visit codes is higher than the values of the comparable office visit codes. Even when CMS recently updated the wRVU assignments for the office visit codes, the general relativity between those codes and their inpatient corollaries was still preserved to a large extent. The third table above shows how the CY 2023 proposal eliminates the historic or current relative relationship between the codes.

We recommend a set of values for these codes that would re-establish the historical relationship between the office and inpatient E/M codes.

- CPT 99221: 1.92 wRVUs
- CPT 99222: 2.79 wRVUs
- CPT 99223: 4.25 wRVUs

To reiterate, we oppose the proposed values for 99221-99223 and urge CMS to adopt values for 99221-99223 that preserve relativity with the comparable office visit codes, either by reestablishing the historical relativity through our recommended values above or, minimally, by maintaining the current wRVU rates for these initial hospital or observation visit codes.

In the discussion of the proposed changes to the values of the E/M codes, CMS made several comments indicating their rationale behind accepting the RUC recommendations. We address these comments below.

CMS stated they did not believe the assumption that patient needs are inherently more complex or the work more intense in non-office settings (i.e., facility settings) than in the outpatient office setting. We strongly disagree with this assertion. While it is true the range of available services and staff complements are very different between the office setting and a hospital, CMS' concerns about increased challenges for gathering information and coordinating care relies on outlier patients, not the average patients, seen in an office-based setting. If a patient requires higher acuity or more intensive care, an office-based clinician will direct the patient to go to the hospital to receive care. Indeed, office-based practices will regularly screen and redirect patients who are having an emergency to go straight to the hospital for care or, in the most severe situations, call an ambulance. Patients who are admitted to the hospital are there because their care requires the higher level of services and care available in the hospital. It is illogical to assert, through these proposed valuations, that the intensity and work required for these patients is identical to the comparable office visit codes. We also remind CMS that hospitals have a widely variable range and availability of resources and ancillary staff to support the care of the

patient. There are considerable differences in resources between small rural community hospitals and tertiary/quaternary care centers in urban areas.

CMS also indicated some CPT E/M code families are being merged, namely the CPT codes for observation services which are for a lower complexity setting being migrated into the inpatient visit CPT codes. This comment does not reflect the proposed values for these initial inpatient or observation E/M codes. We would expect that codes with well-established and accepted historical values being merged would, at a minimum, result in a value somewhere between those two values. This logic would support an average, a weighted average, or some other value that uses the lower value code as the minimum and the higher value code as the maximum. Instead, CMS' proposed values for 99221-99223 fall at or below the existing values of the initial observation visit CPT codes (99218-99220). This makes the proposed values anomalous to the historical relativity of the observation codes to the inpatient hospital visit codes.

The trend in hospitalization is one where patients who are admitted tend to be sicker, while healthier patients are and should be receiving care in outpatient settings as medically appropriate. The proposed valuation of the admission codes suggests admitted patients require fewer services or less intensity of care than their peers who can receive care in outpatient settings. This is fundamentally incorrect. CMS must not finalize the proposed reductions in the hospital visit admission codes.

Coding Changes and Visit Selection

Assuming a fair and equitable valuation for these codes is established, SHM is supportive of the proposed merging of the observation visit codes into the inpatient visit codes, making them inpatient or observation visit codes. We believe this removes complexity from the coding and documentation system. This proposed change also reflects the reality that patients in observation and those admitted as inpatients are largely medically indistinguishable from each other and are commonly cared for by the same care teams on the same inpatient floors.

We note this proposed change does not ameliorate the challenges with determining inpatient or observation status for patients and may present new challenges for other CMS policies that rely on these status determinations, such as the 3-day stay rule for Skilled Nursing Facility (SNF) coverage. We continue to urge CMS to work to simplify its rules around observation care and SNF coverage.

Proposed "8 to 24 Hour Rule" for Hospital Inpatient or Observation Care

CMS proposes to retain its rules around payment of discharge CPT codes 99238 and 99239 when patients are receiving hospital care between 8 to 24 hours. We acknowledge this proposal technically does not change existing rules. In practice, however, these rules do not make sense because patients with anticipated short stays are typically hospitalized under observation services. With the observation codes being merged into the inpatient E/M codes, this policy creates additional confusion because the

"clock" for the "8 to 24 hour rule" starts at the time the initial order was entered or written. Under the Two Midnight rule, the "clock" begins when a beneficiary begins receiving patient-specific services, such as an EKG for a patient with chest pain in an Emergency Department. These distinct start times are frequently hours apart and may cross a midnight. The utilization of the 8-24 hour rule will create the need for clinicians to be aware of two different times (one for status, another for CPT selection) which is not logical and certainly creates meaningful administrative burden.

Furthermore, the requirement to use so called "Same Day" CPT codes adds further confusion. Within an 8-24 hour period, care may be delivered past midnight, meaning care is delivered, by definition, on a different calendar day. This is also highly confusing to clinicians. We encourage CMS to consider how these rules add complexity to the billing and coding system and whether the added administrative burden is justified. Tracking time is an added burden, particularly since hospitalists do not regularly use time to bill E/M codes.

Impact of Changes to Hospital Inpatient or Observation Codes on Billing and Claims Processing Policies

CMS asks for feedback on the impact of the proposed change to collapse the observation E/M codes into the inpatient E/M codes and other E/M related proposals. We encourage CMS to continue to monitor for issues with the implementation of these changes, particularly whether this creates confusion or conflict with the 2-midnight rule for determining patient status in the hospital.

Prolonged Services for Inpatient Hospital or Observation Care

CMS proposed to create a single G-code, GXXX1, that describes a prolonged service in the inpatient setting that can be billed in fifteen-minute intervals. This code would apply to CPT codes 99223, 99233, and 99236. CMS proposed the prolonged service period can begin 15 minutes after the total time of the visit has been completed.

We have concerns about the administrative complexity and feasibility of this proposal. Additionally, this proposal requires significantly more time to qualify for a prolonged visit than the CPT guidelines state. For example, requiring an additional 15 minutes spent with a patient for the index visit, as well as an additional 15 minutes once the "prolonged" service begins, in effect, requires an additional 30 minutes spent with patients to bill for the first prolonged service. This is an exceedingly high threshold to meet and will limit the utility of this code.

CMS indicates they believe they must count time this way to be inclusive of the "total time" associated with the underlying E/M code. They propose first including the post-service time before beginning to count time for a prolonged service. Post-service time can include time spent up to three days after the date of encounter. We believe this post-service time would still be performed *after* the prolonged service, which does not have post-service time itself. **We oppose the policy to begin counting for a prolonged service fifteen minutes after the total times associated with the index visit have been met.**

Prolonged service time should count immediately after the total time is met, which is consistent with CPT instructions.

Prolonged services should be billable when a practitioner reaches the following time thresholds, and at every fifteen minute increment thereafter. These thresholds are total time associated with the code plus fifteen minutes.

- 99223: 90 minutes
- 99233: 65 minutes
- 99236: 95 or 100 minutes

We note the time for 99236 should not include the post-service time associated with the code, which can include work up to three-days post discharge. The prolonged service time would be performed on the date of the service, not within or at the conclusion of the three-day post-discharge period.

We also disagree with CMS' limiting the availability of using GXXX1 to time-based billing for E/M visits. CMS makes available, through its proposals, time or MDM to bill for any of the hospital visit E/M codes. Requiring that the prolonged service code only applies if the underlying service is billed using time effectively limits hospital visit E/M codes to time-based billing. It is common for high-complexity cases in the hospital to be determined on MDM, making them ineligible for prolonged services as needed, despite the patient visit requiring significant added time and effort from the billing clinician. It is often impossible for a clinician hospitalizing a group of patients to know which might require prolonged services. In hospitals today, it is common for patients to be admitted by a hospitalist after midnight but prior to 7 or 8 AM, and to be cared for by a different clinician during the day. Unless the night clinician bills by time, GXXX1 would not be allowed. **CMS must develop policies that enable prolonged services to be billed when a clinician uses MDM to select the underlying E/M service. If necessary, CMS should work with the CPT editorial panel to determine how this could function.**

Split or Shared Visits

In the CY2022 Physician Fee Schedule rule, CMS created a new time-based policy for billing a split (or shared) visit. CMS defined 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." Under the finalized policy, only the provider who performs a "substantive portion [of the visit]" would be able to bill for the entire visit, which, beginning in 2023, was defined as more than half of the total distinct and qualifying time associated with the visit. In 2022, CMS allowed for a transition year where time, MDM, or History & Physical could be used to determine which provider performed the "substantive portion." **SHM raised significant concerns with this policy and continues to be opposed to the split or shared billing policy as promulgated.**

In response to SHM and other stakeholders providing feedback as our members attempted to implement this policy earlier this year, CMS proposed to extend the transition period for an additional

calendar year, meaning that mandatory use of the time-based criterion will be delayed until 2024. **We are supportive of this delay, but we urge CMS to utilize this delay to work alongside relevant stakeholders to develop a more appropriate and improved solution that reflects the reality of team-based care in the hospital.** We continue to stress a time-based definition dramatically disrupts team-based care in the hospital, upends long-established billing and documentation systems, and creates significant, new administrative burdens. Hospitalist groups around the country are already reporting difficulties with implementing the split (or shared) billing policy. We acknowledge the Medicare fee for service system does not and cannot effectuate "team" reimbursements—they are billed by a single NPI. That said, CMS can and should take steps to adjust this policy for 2024 and ensure its policies are not actively inhibiting or disincentivizing team-based care.

We strongly urge CMS to develop a policy that maintains the use of MDM for determining which provider can bill for the split (or shared) visit. An attestation in the medical record will enable CMS to audit and ensure payments are appropriate without mandating time-based billing and jeopardizing team-based care. If a physician makes a meaningful contribution to the care plan of a patient, that physician should be able to bill for the visit. "Meaningfully contribute" could include directly managing care of the patient, altering the care plan for the patient, sharing decision-making with the APP, or other non-token involvement with the patient or APP. We believe this would not include the physician "poking their head in" as referenced in the 2022 Physician Fee Schedule rule or other forms of token involvement. The attestation can indicate the physician meaningfully contributed to the care of the patient and therefore should be able to bill for the split (or shared) visit.

Below are clinical vignettes of team-based care for a split (or shared visit). We would expect the physician could bill for the visit, as their input significantly contributed to or changed the course of care for the patient (it was meaningful).

1. An advanced practice provider is seeing a patient with multiple comorbidities and consultants involved. There is disagreement between consultants on next steps and the care is not moving forward. The APP is communicating with residents/fellows on the consultant teams and is getting the run around (i.e., cardiology says patient needs a pericardial window; Cardiothoracic surgery states that the patient needs a drain placed before a window procedure). The attending hospitalist physician gets involved, discusses the case with APP, calls consultant physicians/surgeons, and is able to generate agreement around a plan to move clinical care forward.

2. An advanced practice provider is working with very sick cancer patient whose family is not open to considering changing code status despite multiple family meetings. The family wants 'everything to be done.' The attending hospitalist physician gets involved and discusses the case with the oncologist who recommends no further treatment for end stage cancer. The attending calls a family meeting, discusses the patient's wishes with family, and consensus is reached to transition the patient to comfort care, consistent with the patient's wishes.

3. A patient admitted with chronic baseline respiratory alkalosis in setting of known obstructive sleep apnea (OSA), obesity hypoventilation. The patient is also grossly volume overloaded. Advanced practice provider team attempts to diurese the patient but is using acetazolamide given concern for worsening alkalosis. No clinical progress. Attending hospitalist gets involved, feels that since alkalosis is chronic, likely mild worsening with loop diuresis will not be an issue, and starts diuresis with IV Lasix. Patient remains stable, diuresis several liters of fluid over the course of the following 2-3 days, is weaned off oxygen, and subsequently discharged to home.

These examples show the value of team-based care and demonstrate meaningful physician involvement with clinical decision-making, communication, and coordination of care and demonstrate why the physician should be able to bill for the split (or shared) visit.

CMS performs audits and reviews records through contractors as part of their normal program integrity work. Any medical record can be reviewed for substantiating evidence that a physician appropriately billed for a split (or shared) visit. In this case, substantiating evidence would be the attestation in the medical record which affirms the meaningful involvement of the physician in the care of the patient.

While the Medicare fee for service system enables time-based billing for all E/M codes, time-based billing works best in settings like an outpatient office, where time spent on an individual patient encounter is more easily tracked. In the inpatient setting, however, time is not commonly used to bill for visits by hospitalists. There are some exceptions, including discharge codes and critical care codes, which are structured as time-based. However, tracking time does not work amid the discontinuous and fluid nature of care in the hospital. Hospitalists balance multiple patients, work with many different healthcare professionals across specialties and provider types, and see patients at multiple points throughout a day, as opposed to sequentially, as one might in an office or critical care setting. Tracking time for a specific patient is very difficult, if not impossible, to do accurately because of this discontinuity. This policy essentially mandates time-based billing for Split (or shared) visits, even in settings where it is not appropriate and more difficult to track. Forcing time-based billing is also contrary to the updated CPT instructions for E/M services, which allow for the use of MDM to bill.

Technical Correction for Split (or Shared) Critical Care Services

CMS issued a correction to 86 FR 65162 that indicated billing 99292 will now require 104 minutes, as opposed to the historical value of 75 minutes of critical care time. Additionally, CPT code 99292 is "reportable for additional, complete 30-minute time increments furnished to the same patient (74 + 30 = 104 minutes.)" This change ignores the historical implementation of the "Mid-Point Rule," in which billing of a time-based code required reaching or exceeding the midpoint of the time range for a given service. CPT 99291 was intended to represent 60 minutes of critical care time – the reason for including up to 74 minutes in the range provided by CPT was that 75 minutes was what was required to reach the midpoint of a 99292, intended to be 30 minutes. The calculation should be (60 + 15 = 75 minutes).

Furthermore, transmittal 2997 of the Medicare Claims Processing Manual, dated July 25, 2014, clarifies 99291 is intended to represent the first hour of critical care time, and 99292 is to be used for each additional 30 minutes:

- *"The CPT code 99291 (critical care, **first hour**) is used to report the services of a physician providing full attention to a critically ill or critically injured patient from 30-74 minutes on a given date. Only one unit of CPT code 99291 may be billed by a physician for a patient on a given date."*
- *"The CPT code 99291 is used to report the first 30 - 74 minutes of critical care on a given calendar date of service. It should only be used once per calendar date per patient by the same physician or physician group of the same specialty. CPT code 99292 is used to report additional block(s) of time, **of up to 30 minutes each beyond the first 74 minutes of critical care (See table below)."***
- *"However, if a physician or qualified NPP within a group provides "staff coverage" or "follow-up" for each other **after the first hour of critical care services was provided** on the same calendar date by the previous group clinician (physician or qualified NPP), the subsequent visits by the "covering" physician or qualified NPP in the group shall be billed using CPT critical care add-on code 99292."*

This proposed "correction" is not supported by CMS policy/precedent, was not evaluated by the AMA RUC, and appears unreviewed by the CPT Editorial Panel. We ask that CMS delay any change to the time requirements for these codes to allow for review of the critical care codes 99291-99292 by the AMA RUC and/or CPT to clarify and correct the calculation put forth in the 2023 PFS proposed rule.

Medicare Quality Payment Program (QPP)

Increased Stakeholder Engagement in MVP Development

SHM understands CMS' intention to move towards MVP reporting with an eventual goal of sunsetting traditional MIPS reporting. Because of this stated intent, we continue to encourage CMS to open as many opportunities as possible to stakeholder feedback, input and collaboration on MVPs, both in general and on specific MVP development. We support CMS' proposal to open a public comment period for candidate MVPs and to provide those comments to the MVP developers and interested parties. We believe this builds on stakeholder outreach conducted by MVP developers and enables additional opportunities for broader stakeholder feedback.

Proposal to Add New MIPS Value Pathways (MVPs)

CMS proposed to adopt five additional MVPs, including Advancing Cancer Care, Optimal Care for Kidney Health, Optimal Care for Neurological Conditions, Supportive Care for Cognitive-Based Neurological

Conditions, and Promoting Wellness. We appreciate that CMS and stakeholder groups continue to develop new MVPs but we continue to be concerned that MVP development is mirroring the slow pace of measure development across the MIPS program, particularly for specialties like hospital medicine that have a dearth of relevant measures and have difficulty being assessed at the individual level.

We reiterate our call for 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 MVPs if they are the future of the program. Hospitalists' very heterogeneous experiences with MIPS participation reflects the diversity of their practice structures, patient mix, and varied employment relationships with their hospitals and health systems. **We continue to urge CMS to keep MVP reporting voluntary for the foreseeable future. CMS should refrain from formally sunsetting traditional MIPS reporting until the agency can ensure that all MIPS eligible clinicians and groups have applicable MVPs in which they can meaningfully participate. If necessary, CMS may need to recognize that the MVP framework may not be suitable for all medical specialties or practice structures and develop alternatives.**

Subgroup Reporting

Beginning with the CY2026 performance period, CMS previously finalized that only single specialty groups will be able to participate as a group for MVP reporting, and multispecialty groups will be required to form subgroups for reporting an MVP. We opposed this proposal in the last cycle of rulemaking and continue to oppose mandatory subgroup reporting for multispecialty groups. While CMS states their intention of ensuring clinicians are participating and reporting on relevant measures, this proposal creates new and additional reporting burdens and may serve as an impediment to team-based care.

CMS proposed to define single specialty and multispecialty groups using data Medicare Part B claims data. **We oppose this proposal and oppose an alternative of using PECOS registration to define single specialty for the purposes of specialty determination in subgroup reporting. Until CMS can better identify specialty, we also continue to oppose mandatory subgroup reporting in MVPs.**

As CMS indicates in their proposal, using Medicare Part B claims data has a variance rate of less than 1 percent from identifying specialty through PECOS. Given this analysis, Medicare Part B claims data is not functionally different from using PECOS registration, meaning it has the same shortcomings. In the average hospital medicine group, the following specialties may be commonly identified using either Medicare Part B claims data or PECOS registration alone: Internal Medicine, Family Medicine, Hospitalist (C6), Nurse Practitioner, and Physician Assistant. All these clinicians are doing essentially identical work and should be viewed as a single specialty group. In the proposed mandatory subgroup reporting, CMS would see this single hospital medicine group as containing five separate subgroups and, therefore, required to report separately using MVPs. Each of these separate subgroups in a hospital medicine group would likely report on the same MVP (assuming a hospitalist-focused MVP is developed). This constitutes a significant added burden to MIPS reporting for no added benefit or more granular,

specialty specific data, and may also create artificial volume threshold issues for smaller clinician groups, if divided in this manner. CMS must find a functional and straightforward way to identify "subgroups" of clinicians who may appear to be of different specialties but are doing the same work.

Subgroup Scoring

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 both 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 clinicians. We ask CMS to take this into account as they are evaluating population health measures for MVPs.

Advanced Payment Model Performance Pathway

CMS asks for feedback on subgroup reporting in the APP. We refer CMS to our comments above about identifying specialties within multispecialty groups, and encourage CMS to address those operational concerns with identifying single specialties prior to implementing subgroup reporting in the APP.

MIPS Quality Performance Category: Health Equity RFI

Throughout the United States, minority groups experience persistent health care inequities and disparities. SHM lauds CMS' commitment to addressing health inequities and its ongoing work to achieve equitable healthcare outcomes for Medicare beneficiaries and all patients.

CMS asks for feedback on incorporating health equity measures in the MIPS and how to make the data meaningful and actionable. We want to encourage CMS to think beyond its programmatic siloes and focus on the experience of a patient when developing and implementing health equity measures in the MIPS. From the hospitalist perspective, the most appropriate level for data collection for purposes of measuring social drivers of health is at the hospital or system level, as opposed to the individual clinician. Patients will be screened by hospital staff for the hospital-level health equity measures, and it would then be redundant for the hospital-based clinicians to perform the same measure activity to meet MIPS requirements. The information gleaned from the facility screening will be available within the health records and accessible to the entire hospital care team. The appropriate stakeholders within the hospital care team would then be able to use this information to inform the care or marshal available services that could help improve outcomes for the patient. CMS should be thoughtful about the

appropriate level of reporting for health equity measures and not try to pursue a one-size-fits-all approach in the MIPS program.

CMS also asks about self-reported demographic information. Collecting demographics data can be challenging and resource intensive, with hospitals relying on both intake staff and digital resources for such collection. While self-reported demographic data is the gold standard of demographic data collection, it is important to recognize that marginalized populations may be uncomfortable disclosing this information for fear of retribution, bias, or abuse. For example, patients may refuse to disclose demographic information like sexuality, gender identity, or tribal affiliation out of concern that this information will negatively impact their care. We raise this concern to note that even self-reported data has its own biases and may not accurately capture the range of experiences or risks faced by a given population.

Self-reported data without standardized fields will limit the applicability of the data and prevent data analysis and comparison. Therefore, we believe CMS should develop and establish a standard set of demographic categories to ensure data on beneficiaries in different states or healthcare systems can be appropriately compared.

We support the collection of this demographic information but are concerned about the feasibility within current EHR systems. Not all EHRs are designed to collect advanced demographic information. Hospitals may struggle to accurately collect gender identity, for example, because the hospital records may be designed to collect binary gender information. This is just one example that demonstrates the struggles with collecting complex and nuanced demographic information with existing tools and software. CMS must work to develop a standardized field of questions that will not create excessive administrative burden and can be incorporated into existing EHR structures and reporting processes. Changes to existing EHR capabilities can come with substantial costs and are often time- and labor-intensive. These burdens should not fall on the hospitals and clinicians who are the front-end users of EHR systems.

We also continue to encourage CMS to consider how they can identify and utilize existing resources that currently track race and ethnicity data. Many community-level indices, like the Community Needs Index (CNI), collect demographic data. Rather than creating duplicative reporting structures, CMS may find the requisite information is already collected and recorded and can be repurposed for CMS' reporting purposes. Using existing indices will ensure CMS and hospitals have access to information to address health outcomes disparities without creating new and potentially costly administrative tasks for hospitals and healthcare workers or demanding even more paperwork from patients at a very vulnerable time in their life.

Removal of Measure 076: Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections

CMS proposes to remove Measure 076 from the MIPS program, and by extension it will be removed from the hospitalist specialty set, as it has reached the end of its topped-out lifecycle. **We support removal of Measure 076 from the hospitalist specialty set.**

However, SHM does express reservations about removing Measure 076 from the MIPS program entirely. The measure has served as an important impetus for driving the implementation of bloodstream infection control protocols and improved systems around CVC insertions. Retaining the measure may help ensure improvements in infection control do not backslide. SHM encourages CMS to continue monitoring for negative changes in outcomes for patients and, if necessary, consider reimplementing Measure 076 or alternative measures in this area.

Screening for Social Drivers of Health Proposed Measure

CMS proposes to implement a Screening for Social Drivers of Health measure across the MIPS. The proposed measure assesses the percent of patients 18 years or older who are screened for food insecurity, housing instability, transportation problems, utility difficulties and interpersonal safety. In addition, CMS proposes to add the measure to the specialty sets.

SHM strongly agrees with the need to systematically address social determinants of health. We agree that screening and measurement can be an important first step to illuminate disparities in our communities. During the Measures Under Consideration (MUC) process, we asked for more information about the specifics of the measure, including how screenings for these social drivers of health should be performed. We continue to ask CMS for more detail about the measure to aid in detailed evaluation and ultimately implementation.

We caution against applying the proposed Screening for Social Drivers of Health measure in a one-sized-fits-all approach across the MIPS program and are opposed to inclusion of this measure within the hospitalist specialty set. CMS has already finalized this measure and an additional measure (Screen Positive Rate for Social Drivers of Health) in the CY 2023 Inpatient Prospective Payment System Rule, with mandatory reporting beginning in the 2024 reporting/FY2026 payment period. Patients seen by hospitalists and other hospital-based clinicians will already receive screening for these social drivers of health as hospitals begin to report the hospital-level measures. This means the data will already be captured and documented in the Electronic Medical Record (EMR) used by those hospitalists. We believe it would be duplicative and counterproductive to create a requirement for hospitalists and other hospital-based clinicians to screen patients again for these drivers of health. Indeed, repeated screenings within the same episode of care has the potential to create distress for patients. CMS should be more targeted with their implementation of this measure in the MIPS to guard against duplicative data collection and to ensure relevance.

Complex Patient Bonus: Eligibility

CMS has proposed that, beginning with the 2023 performance period, a facility-based MIPS eligible clinician would be eligible to receive the complex patient bonus, even if they do not submit data for at least one MIPS performance category. **We strongly support this proposal, as it creates equitable opportunities for facility-based clinicians to receive the complex patient bonus in the MIPS program.**

Facility-based Measurement

CMS proposes to expand and clarify their definition of a facility-based MIPS eligible clinician to include those who practice in virtual groups. **We support this proposal as it makes facility-based measurement available for all MIPS eligible clinicians who otherwise meet the facility-based eligibility criteria.**

MIPS Payment Adjustments: Establishing the Performance Threshold

CMS proposes to set the performance threshold for the 2025 MIPS payment year at 75 points, which is approximately the mean associated with the 2019 MIPS payment year. We support this proposal and concur with CMS' assessment that, with scoring and other programmatic changes, the mean MIPS final score may be lower in 2025 than the means from the 2020-2022 MIPS payment years.

Conclusion

SHM appreciates the opportunity to provide comments on the FY 2023 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,

Rachel Thompson, MD, MPH, SFHM
President, Society of Hospital Medicine