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The Honorable Dave Camp
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

RE: Response to Second Iteration SGR Reform Proposal

Dear Chairmen Camp and Upton:

The Society of Hospital Medicine (SHM), representing the nation's nearly 40,000 hospitalists, appreciates the opportunity to comment on the second iteration of the Joint Energy & Commerce and Ways & Means Committees sustainable growth rate (SGR) repeal and reform proposal. We cannot emphasize enough the importance of fully addressing the SGR and reforming the payment system.

Practitioners of hospital medicine ("hospitalists") include physician and non-physician providers who engage in clinical care, teaching, research, or leadership in the field of general hospital medicine. In addition to their core expertise managing the clinical problems of acutely ill, hospitalized patients, hospitalists work to enhance the performance of hospitals and healthcare systems. It is this perspective that informs the following comments on this proposal.

SHM broadly lauds the goals outlined in the reform proposal, particularly as they would ensure the engagement and empowerment of the provider community to be meaningful actors in quality improvement and measurement for the purposes of federal programs. Specialty societies should be proactive and engaged in advocating for and shaping a pay-for-performance agenda. There can and should be a leadership role for specialty societies in quality improvement and payment reform.

Feedback on Proposal

A. Phase I: Stable, Predictable Updates

SHM strongly agrees that the SGR needs to be repealed to create stability in the physician payment system. Predictable updates to the fee schedule will allow providers and their specialty organizations to focus their efforts on developing and implementing quality measures and improvement activities. SHM cautions, however, that the

language in the statute should be written so as not to create a new and unsustainable status quo within the payment system wherein there is no will or ability to move towards meaningful payment policy reform. Expectations in the statute should be clear that this phase is temporary and meant to serve only as a period of transition to reforms.

The Phase I proposal should be expanded to include plainly articulated activities and objectives to be achieved by providers and specialty societies in order to ensure preparedness for Phase II and beyond.

B. Phase II: Portion of Payment Based on Quality through Update Incentive Program (UIP)

Phase II of the proposal moves providers onto a payment system wherein part of their payments would reflect their performance on quality measures and/or clinical improvement activities.

SHM offers the following comments on elements of the Phase II proposal:

- *Score on quality measures relative to their peers.* SHM strongly encourages that any performance measurement system account not just for differences among specialties, but also for differences within specialties. Clinically meaningful and applicably quality measures would be most actionable for quality improvement processes when making comparisons between peers. The proposal seems to support this idea that peer comparison, which might be broader than simply specialty designation, would be most useful for a quality improvement and pay-for-performance program.

Hospitalists overwhelmingly hold an internal medicine specialty designation, but have significant divergence in practice patterns and costs when compared to traditional outpatient internal medicine providers. Hospitalists practice primarily in hospitals or other institutional settings and, as a result, they see a sicker and more expensive patient population than other internal medicine physicians.

For this reason, it is critical that any quality improvement and quality-linked payment system allows for comparisons between peer groups that include comparable specialty and practice type within that specialty. For quality measures to be useful and meaningful, hospitalists need to be compared to other hospitalists and indexed to similar patient acuity. Flexible reporting structures would allow physicians to self-select into a measurement and comparison model that best suits their practice size, patterns and locations. For hospitalists, a process of self-designation as hospitalists would allow them to appropriately categorize themselves. Knowledge that they are being accurately measured and appropriately compared to similarly situated peers will encourage physician engagement in P4P and, ultimately, drive quality and cost improvement efforts.

- *Flexibility for providers to choose the level of their assessment.* It is critical, particularly for hospitalists, to be assessed in ways that match their practice patterns. Much of hospital medicine is comprised of shift work, meaning that individual-level performance does not

accurately reflect the quality of care or make sense for quality measurement/improvement purposes.

Additionally, assessment of quality of care and service unique to the specialty of hospital medicine may be best reflected at the group or hospital-level, rather than at the individual practitioner level. As a hospital-based specialty, an individual hospitalist's quality and performance results will be closely tied to the hospital-level performance agenda. Therefore, SHM recommends that hospitalists be given the option to link the hospital-level performance results primarily associated with a group of hospitalists. Physicians selecting this option would identify which hospitals and hospital measures would be relevant, harmonizing physician-level and hospital-level performance reporting.

- *Minimizing the participation burden on providers.* As has been widely commented on in the provider community, the often-overlapping, yet sometimes-exclusive requirements associated with many of the current programs being implemented by CMS places a great deal of strain and disincentive for providers to participate. SHM strongly supports any initiative that would seek to reduce the administrative barriers to participating in these programs. Many of the administrative burdens, however, are borne out of mismatched legislative requirements. These include the incentive and payment adjustment periods for PQRS and the value modifier, statutory requirements on participation and exemptions from programs like Meaningful Use, and the timelines for when programs must be operational. SHM recognizes the importance in allowing regulatory flexibility through the Secretary, but cautions that there are statutory obstructions that must be addressed as well.
- *Providing timely feedback and review of results.* One of the central criticisms of many of the current quality programs is that the time lag between performance and adjustment does not allow for meaningful quality improvement. SHM concurs with the assessment that, for example, the current 2 year span between performance and adjustment in the physician value-based payment modifier undermines the quality improvement purpose of the program. Performance reporting must be done in as close to real time as possible.
- *Acceptance of Quality Measures.* SHM appreciates the flexibility inherent in the proposal. As written, it would require the immediate acceptance of all measures endorsed by a consensus-based organization like the National Quality Forum (NQF) and acceptance of all measures that meet a set of statutory criteria but lack endorsement. While SHM affirms that all measures should ultimately undergo an endorsement process by an organization like the NQF, it is important to recognize that, as the UIP operationalizes, not all measures will have gone through the formal endorsement process. Allowing measures that meet certain criteria, are evidence based and generally accepted, but have yet to achieve endorsement, may, in part, help specialties that have not yet established sufficient quality measures. However, we caution that any use of such measures should be provider-initiated and a temporary solution only for measures that are undergoing the NQF endorsement process.

- *Specialty society/provider driven quality measures.* The proposal recognizes that there is a gap within the provider community for those specialties that do not have sufficient quality measures. This is a critical barrier for many specialties towards meaningful participation in federal quality improvement and pay for performance programs. It is clear that within the current organization of the healthcare system, not all specialties have the resources and capacity to develop meaningful quality measures. The methodology in the proposal to further decentralize quality measurement development may further exacerbate this issue.

For hospitalists, the problem is not always the lack of appropriate measures, but that specifications for existing measures often prevent hospitalists from reporting them when relevant. This most frequently occurs because of the inpatient/institutional nature of the care hospitalists provide. The current process for quality measure development requires the measure developer, who often does not have the interest or capacity, to make the changes necessary in order for the measure to be reportable by hospitalists.

SHM firmly believes that quality measures must be meaningful for the practice of medicine and designed not just for the sake of measurement but to ultimately improve the quality of care. Reporting just for the sake of reporting is not useful for providers and does not benefit patients, but is simply added administrative burden. The challenge, then, is to encourage measure creation that encourages quality improvement. There should be, both in statute and in the expectations for the Secretary, incentives to encourage continued innovation and creation of quality measures for all specialties. To reach this goal, a balanced approach must be identified that blends centralized strategic oversight coupled with financial and technical assistance.

SHM would like clarification on the following elements of the Phase II proposal:

- *Credit for successfully participating in the UIP.* “Providers will have three ways to receive *credit* (emphasis added) that will determine their variable, performance-based score.” The three options include peer comparison score on quality measures, self-improvement on quality measures and completing clinical improvement activities. It is not clear how “credit” would be allocated between the different options. SHM is concerned that one option or another could be inadvertently preferred by providers if the level of administrative time and complexity differs significantly between the options. All options should be implemented with care so as not to be overly burdensome.
- *Coordination with other CMS programs.* The UIP, as drafted in this iteration of the proposal, appears to be an additional program in conjunction with programs already offered through the Centers for Medicare & Medicaid Services (CMS), such as PQRS and Meaningful Use. As articulated, the UIP also bears striking resemblance to the value-based payment modifier, which seeks to connect quality measurement with payment adjustments. Further clarification on the interconnection between the UIP and other programs, including the value-modifier, would be necessary in order to fully evaluate a proposal.

- *Sufficiency of Measures.* SHM would like clarification on what is meant by having “sufficient quality measures” for each specialty. In the current design of CMS programs, sufficient is an arbitrary threshold whereby providers must either report on one measure to avoid a penalty, or three measures, in order to earn an incentive.

C. Phase III: Reward for Efficient Resource Use

Phase III of the proposal combines the quality measurement from Phase II with an evaluation of the providers’ use of resources. SHM appreciates that this Phase would allow the on-going involvement of physician organizations to help create the methodology through which efficiency would be evaluated.

With the current state of efficiency measurement, significant time and energy will be required to refine methodology for attributing the efficient use of health care resources. After several iterations of current attempts to measure and attribute resource use through Quality and Resource Use Reports (QRURs), the methodology employed still does not encompass or accurately portray all providers. Indeed, hospitalists, by the nature of their practice, would likely not receive data on resource use.

It is clear that any evaluation of resource use must be designed in a way that captures the differences between physician practices and must be conducted as close to real time as possible. Much like our concerns for quality measures, efficiency assessments need to be intentionally crafted so that physician practices are provided with the timely information necessary to improve their resource use.

D. Provider Opt-Out for Alternate Payment Model (APM) Adoption

SHM commends the proposal for allowing flexibility for providers who are participating in other payment models to opt-out of the UIP. This would ameliorate the confusing statutory reality that providers face in the coming years. For example, ACO participants will need to be evaluated in the physician value-based payment modifier by 2017. It would be duplicative to require providers to report in a quality measurement program such as the UIP, while they are participating in alternative payment arrangements like ACOs that are likely structured around a different set of quality metrics.

There are a number of programs offered through CMS and the Center for Medicare & Medicaid Innovation that would seem to be a natural fit for this exemption. For example, the Medicare Shared Savings Program, the comprehensive primary care initiative and the Pioneer ACO model are programs that CMS recognizes as significant enough to allow temporary exemptions from the physician value-based payment modifier. This proposal, as written, would allow these temporary exemptions to be extended beyond 2017.

E. Reports on Improved Provider Fee Schedule and Alternate Payment Methods

SHM agrees that to increase transparency and continued stakeholder involvement in the policy development process, regular reports must be submitted to Congress. These reports, while important to Congress as a way to evaluate the progress of the programs, also allow specialty societies to have a

better understanding of how programs are being implemented and, therefore, provide more pointed and informed feedback.

F. Improvements upon Current Law

SHM wants to underscore the importance of this area and encourages future proposals to specify what improvements to current law would be enacted. As commented on earlier in this letter, current CMS programs often create uneven and overlapping expectations for providers. These problems result in confusion, frustration, and apathy towards federal quality improvement and pay-for-performance programs. This proposal represents a tremendous opportunity to both simplify and align the disparate nature of programs such as PQRS, Meaningful Use and the Physician Value Based Payment Modifier.

We recommend that future iterations of this proposal look at areas in current law that can be built upon, refined or unified to meet the same objectives outlined in this proposal.

Conclusion

We hope these comments underscore the importance of improving the payment system and quality improvement activities, while reducing administrative burden and confusion for providers. Thank you for the opportunity to provide comments on this legislative proposal. If we can be of further assistance or provide any additional information, please contact Joshua Boswell, Senior Manager of Government Relations at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,



Shaun Frost, MD, SFHM, FACP
President
Society of Hospital Medicine