August 21, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program: Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Quality Improvement Organization Regulations. (CMS-1589-P)

Dear Acting Administrator Tavenner:

The American College of Physicians (ACP) appreciates this opportunity to comment on the above referenced Hospital Outpatient proposed rule--our comments only focus on section XI of the rule pertaining to "Outpatient Status: Solicitation of Public Comment." The ACP is the largest medical specialty society and second largest physician membership organization in the United States, representing 133,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults and medical students who are considering a career in internal medicine.

The College is concerned by the increased frequency of beneficiaries in hospital settings being categorized as outpatients receiving observation services rather than regular inpatient admissions. A recent study found that the ratio of observation stays to inpatient admissions increased 34 percent between 2007 and 2009.[1] Furthermore, the proposed rule indicates that in recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours has increased from approximately 3 percent in 2006 to approximately 7.5 percent in 2010. This trend has a profound effect both on the facilities in which our members provide medical services in the form of reduced income that typically does not cover the cost of resources provided, and the beneficiaries receiving these services who unnecessarily become at risk for increased costs through Part B deductibles and coinsurance, and have difficulty meeting the 3 day inpatient requirement for Medicare skilled nursing facility coverage that is often necessary following these interventions.

[1] Feng Z., Wright B., and Mor V. Sharp rise in Medicare enrollees being held in hospitals for observation raises concerns about causes and consequences. Health Affairs, 31. No.6 (2012): 1251-1259

The proposed rule discusses that "hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services, often for longer periods of time, rather than admit them." The recent study mentioned above posits the same hypothesis.[2] The risk of such denials has been heightened with the nationwide implementation of the Medicare Audit Contractor Program in 2006.

The proposed rule solicits public comment on several issues related to this trend of increased use of observation services. The College offers the following comments and recommendations to this solicitation:

- CMS requested public comment regarding whether and how current instructions can be improved regarding Medicare hospital admission policies. --- The College agrees with the statement in the Medicare Benefit Policy Manual "that the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors." [3] The further guidance provided is offered in rather vague terms (e.g., the patient's history and current medical needs; the severity of signs and symptoms exhibited; the medical predictability of something adverse happening) with minimal operational reference, which makes it difficult for the physician to be assured that the admission meets Medicare coverage criteria. The College recommends that:
    - These current general admission criteria be replaced or at least clarified through the use of the large number of evidence based guidelines covering a variety of conditions frequently involved in the hospitalization decision-making process (e.g., chest pain, heart failure, chronic obstructive pulmonary disease) offered through the Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearinghouse (http://guideline.gov/browse/by-topic.aspx) and other sources (e.g., the various medical specialty societies). It is essential that CMS be clear and transparent in their admission coverage criteria. The process of incorporating these guidelines within the admission criteria should include participation of the medical community.
        - Any changes made in the admission criteria should be coupled with a comprehensive educational campaign on these new policies to physicians and hospitals.
    - The opinion of the admitting physician be given increased "weight" in the coverage determination process. Currently, admissions are reviewed by the Medicare contractor, and, when denied, little information is provided regarding the reason for denial. The facility has the option to appeal this decision, but the "burden of proof" is clearly that of the facility and admitting physician. More appropriate, would be a process where any denial of an admission by the contractor be supported by clear documented evidenced-based reasons; thus placing increased "burden of proof" on the contracted reviewer.

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[2] ibid.

[3] Centers for Medicare and Medicaid Service. Medicare Benefit Policy Manuel; Chapter 1 (Page 7). Available at: http://www.google.com/url?sa=t&rct=j&q=medicare%20benefit%20policy%20manual&source=web&cd=3&ved=0CFUQFjAC&url=http%3A%2F%2Fwww.cms.gov%2FRegulations-and-Guidance%2FGuidance%2FManuals%2Fdownloads%2Fbp102c01.pdf&ei=PXcyUNv2Mo6E8QSA2IHICA&usg=AFQjCNFpkVMAsLWOQV9sULAghkevQuI2Wg

  - Related to the above recommendation, it is further recommended that prior to any denial of admission by a Medicare contractor, the denial be reviewed and confirmed by a physician. As mentioned previously, the decision to admit is a complex process that can only be understood by someone with medical training and actual "real life" experience having to decide whether a patient requires inpatient care. The College's concerns regarding the qualifications of the individuals currently making these inpatient denial decisions was recently exacerbated when one of our members forwarded to our staff a job notice from one of the MAC contractors for an "appeals representative," which listed the educational requirement as being a "high school diploma or GED." [4]
- CMS requested public comment on whether aligning payment rates more closely with the resources expended by a hospital when providing outpatient care versus inpatient care of short duration might reduce payment disparities and influence financial incentives and disincentives to admit. --- The College believes that this approach, coupled with improved clear and transparent inpatient admission criteria, will have a significant effect in reducing the trend towards inappropriate, increased use of observation status. Both the proposed rule and the American Hospital Association (AHA) RacTrac survey [5] reflect that a significant proportion of inpatient admission denials consist of short (1- or 2-day) stays where the beneficiary received medically necessary services that the Medicare contractor determined should have been provided as outpatient services and not as inpatient services. The primary difference between the inpatient and outpatient setting is the availability of nurses (and related staff) and advanced technology in the inpatient setting, which accounts for the added cost of inpatient care. Given the complexity of the inpatient decision and the clinical judgment needed to decide whether a patient requires access to these inpatient resources, a recommended approach would be to create a new short term inpatient DRG code that would cover many of these short term inpatient stays where the physician believes these components are necessary. This would provide reasonable reimbursement to the treatment facility that covers the additional labor and technology resource costs, as well as avoids unnecessary increased cost and barriers to possibly needed SNF care to the beneficiary.
- CMS requested public comment regarding whether it may be appropriate and useful to establish a point in time (e.g., 48 hours) after which the encounter becomes an inpatient stay if the beneficiary is still receiving medically necessary care to treat or evaluate his or her condition under an outpatient observation services status. --- The College understands that this approach would protect the beneficiary from excessive Part B charges and potential denial for subsequent SNF coverage, but would still leave the facility at risk if the inpatient admission was denied. Thus, this approach is not recommended unless there is greater clarity and transparency in inpatient admission criteria as outlined above.
- CMS requested public comment regarding holding hospitals responsible to utilize "all of the tools necessary" to make appropriate initial admission decisions e.g., expanding the availability of case management (CM) and utilization review (UR) staff available to assist in decision-making outside of regular business hours. --- The College doesn't recommend the expansion of CM and UR services as an effective approach to this issue. While significantly adding to administrative expense, its ability to improve the current problem with inpatient

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[4] Novitas Solutions. Accessed at http://www.candidatecare.com/srccsh/job.guid?_reqID=2000013494610&_cache=-5148974444839500882&x=71565
[5] American Hospital Association. AHA RACTrac Survey. Accessed at http://www.aharactrac.com/

denials and increased use of observation services remains hampered by the current lack of clarity and transparency regarding the hospital inpatient admission criteria.

The proposed rule further provided details regarding the voluntary three-year AB billing demonstration that began in January, 2012. Under this demonstration, participating hospitals are able to bill for denied inpatient admissions at 90 percent of Part B services (minus deductibles and co-insurance) that would have been medically necessary had the beneficiaries originally been treated as outpatients and not admitted as inpatients. In addition, Medicare beneficiaries are protected from any adverse impacts of this
expanded rebilling. While the College appreciates that this demonstration provides an opportunity for hospitals to receive greater reimbursement to cover expended resources than would be allowable under current regulations covering denial of a discharged patient's admission, it should be noted that:

- Even this increased reimbursement doesn't typically cover the cost of resources provided within the inpatient setting.
- In order to obtain this expanded reimbursement, participating hospitals must forfeit their appeal rights associated with denied inpatient claims. Given that a large percentage of denials are overturned upon appeal,[6] the requirement for a hospital to forfeit its appeal right can have significant financial consequences.

Rather than expanding across the healthcare system the provisions of this demonstration, the College recommends the above stated recommendations of developing clearer and more transparent inpatient admission criteria and establishing a new DRG code to cover these short-term, inpatient admissions.

Please contact Neil Kirschner, Ph.D. on our staff at nkirschner@acponline.org or 202 261-4535 if you have any questions regarding these comments and recommendations.

Respectfully,

Robert Gluckman, MD, FACP
Chair, Medical Practice and Quality Committee

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[6] ibid