American College of Physicians
Leading Internal Medicine, Improving Lives

August 6, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, S.W.,
Washington, DC 20201

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals under the Hospital Inpatient Prospective Payment System (CMS-1633-P)

Dear Acting Administrator Slavitt:

The American College of Physicians (ACP) appreciates this opportunity to comment on the above referenced Hospital Outpatient Prospective Payment System proposed rule for FY 2016. Our comments focus only on section XV of the rule pertaining to "Short Inpatient Hospital Stays."

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 143,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The College appreciates the on-going efforts of CMS to address the problem of the increased frequency of beneficiaries in hospital settings being categorized inappropriately as outpatients under observation status for extended periods with potentially significant adverse financial consequences, which is fueled by hospital concerns regarding potential denial of relatively short inpatient stays. We also appreciate the Agency's efforts to address the related issue of the need for improved clarification to criteria used in determining the appropriateness of a short-term inpatient admission.

Previous efforts by CMS to address these issues included:

- Clarifying admission criteria through the establishment of the two-midnight benchmark under which stays expected to last two or more midnights would be considered (presumed) appropriate for inpatient payment (Part A), while stays expected to last less than two midnights would generally be considered appropriate for outpatient payment (Part B). In assessing the expected duration of necessary care, the physician (or other

practitioner) may take into account outpatient hospital care received prior to inpatient admission.

- Making changes to the Recovery Audit Contractor (RAC) Program to allow a hospital to have a reasonable opportunity to rebill for medically necessary Medicare Part B inpatient services if a medical review contractor has denied a Medicare Part A inpatient claim based on length of stay.

The above referenced rule proposes two additional changes to address further the issues of short hospital stays and hospital admission criteria. The College supports both of the following changes:

- A modification to current policy regarding exceptions to the two-midnight benchmark. More specifically, current policy allows Part A payment for admissions of less than two midnights only in cases involving services specifically designated by CMS as inpatient only and those "rare and unusual circumstances" published on the CMS Web site or in other subregulatory guidance. The proposed modification would broaden the exception criteria to allow determination on a case-by-case basis using supporting clinical documentation by the physician responsible for the care of the beneficiary. The following factors, among others, would be relevant in this determination:

  - The severity of the signs and symptoms exhibited by the patient;
  - The medical predictability of something adverse happening to the patient; and
  - The need for diagnostic studies that are more appropriately outpatient services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).

  This change not only broadens appropriate exceptions to the two-midnight benchmark that are supported by clinical documentation, but also it reinforces the importance of physician judgement in making the difficult determination of the medical necessity of an inpatient admission.

- A revision to the current medical review strategy for short term hospital stays by requiring that Quality Improvement Organization (QIO) contractors conduct the reviews rather than the Medicare Administrative Contractors (MACs). More specifically, QIOs will review a sample of post-payment claims and make a determination of the medical appropriateness of the admission as an inpatient. QIOs will refer claim denials to the MACs for payment adjustments. Furthermore, QIOs will educate hospitals about claims denied under the two-midnight policy and collaborate with these hospitals in their development of a quality improvement framework. Under this QIO short-stay inpatient review process, those hospitals that are found to exhibit a pattern of practices, including, but not limited to having high denial rates and consistently failing to adhere to the two-midnight rule (including having frequent inpatient hospital admissions for stays that do not span one midnight) or failing to improve their performance after QIO educational intervention, will be referred to the RACs for further payment audit.

  The College views this as a very positive change in CMS' medical review strategy. It has become obvious, through a history of high frequency of short-term inpatient hospital stay denials and resulting appeals (often successful) that the current strategy has been less than satisfactory. We believe that having the QIOs conduct the initial reviews of these short term

hospital stays, organizations that have no financial incentive (as do the MACs) to deny claims and that have a mission and successful record of providing education and improving quality, will facilitate hospitals' clearer understanding of short term inpatient admission criteria and reduce the need to use observation status inappropriately.

The College is disappointed that the rule did not more fully address the need for increased beneficiary protections, which would negate or significantly limit adverse financial consequences to beneficiaries who experience stays under observation status, or who have their short inpatient stays denied. We support the proposed observation comprehensive ambulatory payment classification (c-APC) that would protect beneficiaries receiving defined sets of services from being billed for a separate co-pay for each service provided while under observation status, which can become quite costly. The following additional protections, several of which were included in the Medicare Payment Advisory Committee's (MedPAC's) June 2015 *Report to Congress*, are offered for your consideration:

- The beneficiary's financial liability should be limited to the smaller of payments that would be required if the stay was billed by the inpatient facility under Part A or Part B in situations when an inpatient admission is denied;
- The 3-day hospital stay requirement for Skilled Nursing Facility (SNF) coverage should be eliminated, or, minimally, CMS should allow outpatient observational days to count towards meeting the requirement;
- Timely notice to beneficiaries if on observational status, including an explanation of potential financial obligations, should be required; and
- Packaged payment for self-administered drugs should be included in the observation status prospective payment.

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 McLean, MD, FACP
Chair, Medical Practice and Quality Committee