

August 27, 2015

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
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RE: CMS-1633-P: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals under the Hospital Inpatient Prospective Payment System

Dear Acting Administrator Slavitt,

The Society of Hospital Medicine (SHM), representing the nation's 48,000 hospitalists, is pleased to submit comments on the proposed changes to the two midnight policy included in the Outpatient Prospective Payment System proposed rule FY 2016. SHM shares CMS' commitment to improving the quality and coordination of care, and commends CMS' efforts to continually improve healthcare for Medicare beneficiaries throughout the nation. Hospitalists provide care to hospitalized patients, including many Medicare beneficiaries, and often lead the coordination of patient care during a hospital stay, including the transition to the outpatient spectrum.

We appreciate the opportunity to review and provide the following comments on the two midnight rule policy changes mentioned in the proposed rule:

Two Midnight Rule

CMS proposes several reforms to the two midnight rule, which governs the status of patient hospital admissions—inpatient or observation (outpatient). This policy was enacted with the goal of simplifying the inpatient admission decision and reducing the number of long hospital stays under observation status. SHM does not believe the two midnight rule is the optimal policy for addressing the structural issues associated with observation status payment policy. As a start to addressing these issues, we urge CMS to revise its definition of inpatient care, for purposes of qualifying for Part A SNF coverage, to count all time spent by a patient in the hospital.

Despite ongoing concerns with observation policy overall, we appreciate CMS' efforts to modify the two midnight rule to address widespread concerns and issues identified by the provider community. Our comments on the two midnight proposals are as follows:

Expanding Rare and Unusual Exceptions

CMS proposes to change the two midnight rule by altering the "rare and unusual" exceptions policy to allow exceptions beyond the inpatient-only service list to be determined on a "case-by-case basis by the physician responsible for the care of the beneficiary, subject to medical review," with the expectation that stays under 24 hours would only rarely qualify as an exception. SHM appreciates this added flexibility as a way to account for clinical situations wherein a patient may require a short hospital stay, but is in need of extensive hospital resources that, in the absence of time-based criteria, would otherwise require an inpatient stay.

Proposed Modifications to Audits

CMS is opting to move the frontline of inpatient decision reviews from Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) to Quality Improvement Organizations (QIOs). SHM appreciates CMS' intent in making this modification, however, the operationalization of these regulations will depend almost entirely on the ability and capacity of the auditors. We ask that CMS provide more information on what oversight and guidance CMS intends to develop as part of implementing these changes.

Short Inpatient Stay Guidelines

SHM understands it is difficult to create a one-size fits all policy around short inpatient stays and acknowledges the need to create balance between the various competing interests in the healthcare system. We note that given experience in the Probe and Educate period and the Recovery Audit program, hospitalists are skeptical of how a review system can be implemented that respects physician autonomy and decision-making. The various contractors involved in reviewing and issuing payments have shown a propensity for interpreting CMS policies in varying and sometimes contradictory ways. For example, in a recent study at three academic medical centers, one-third of all appeals of Complex Part A denials were overturned in favor of the hospital in the discussion period, indicating that the RAC medical director disagreed with their own auditors' initial payment denial¹. More robust and concrete guidelines on criteria for short inpatient status are needed to avoid unnecessary denials and appeals and overall confusion for beneficiaries and providers.

We are also concerned by the combined use of a 24-hour time period and number of midnights in determining an exception, as it may be confusing and difficult to operationalize. A less than 24-hour stay

¹ Sheehy A, Locke C, Engel J et al. Recovery Audit contractor audits and appeals at three academic medical centers. J Hosp Med. 2015; 10(4):212-219.

will still commonly cross one midnight, which will make it difficult for providers to both keep track of midnight stays, as well as the actual length of stay in hours. For example, an acutely ill patient admitted at 7 p.m. on a Monday who improves enough to be discharged by 5 p.m. on Tuesday has not stayed 24 hours but has spent one midnight in the hospital. If a provider feels the medical acuity justified inpatient status, they may not realize the one midnight stay was not a 24-hour stay, and under Medicare rules, assigning inpatient status would generally not be appropriate. Given that the status determinations are a billing distinction, and have very little to do with actual clinical care delivered, many providers will struggle with this additional layer of regulation. Clear and consistent language needs to be provided in the final rule that would better align these two measures of time (hours and midnights) that a beneficiary spends in the hospital.

We also caution that more clarification is also needed in terms of how exactly this policy is different from the standards that existed prior to the two midnight rule implementation and how physician determinations are to be reviewed and respected.

Recovery Audit Program Proposed Changes and Implementation

We appreciate that CMS is acknowledging the problems inherent in the RAC program by opting to make QIOs first line reviewers. While QIOs have previously focused on improvements in clinical care, it is our hope that with proper preparation, QIOs will prove to be better partners throughout the review process. Although we fully support this move to QIO review and see it as having the potential to significantly improve the current review process, we do have some concerns regarding the proposal.

QIO Structure and Payment

We, first and foremost, ask that CMS clarify how QIOs will be paid to supervise status determinations. Payment should be structured in ways that avoid the fee-based contingency structures that created a complicated incentive structure for the RACs. SHM believes the RAC contingency fees have encouraged a culture of excessive auditing, in turn negatively impacting the clinical decision-making process. We stress that the use of QIOs should not recreate this dynamic and should focus on ensuring that patients are receiving the appropriate care with the appropriate resources, and respect physician judgment.

Historically, QIOs have focused primarily on clinical care, and as inpatient and outpatient status determinations are billing distinctions that have very little to do with the actual quality of clinical care, we advise CMS to provide training and resources to the QIOs so that they may successfully perform this role.

The new short inpatient stay medical review process will maintain that QIOs review a sample of post-payment claims and make a determination of the medical appropriateness of the admission as inpatient, but the timing of this process is unclear. SHM is concerned that hospitals will not have time to revise billing status for claims that are identified as incorrect by QIOs and ask that CMS provide clarification on this timeline.

Further Clarification Needed: Outlier Hospitals

SHM believes significant fundamental RAC reform is still needed, including potentially eliminating the contingency fee structure altogether. As some outlier hospitals will still be referred to the RACs, further clarification on how changes to the RAC program will interface with these proposed changes is needed, as well as a more concrete definition of what makes a hospital an outlier.

Probe and Educate Program

Under the current Probe and Educate program, MACs conducted pre-payment probe reviews as a sample of claims. The Probe and Educate program is set to expire on September 30, 2015. We appreciate the responsiveness of CMS as exhibited in the extension of the Probe and Educate program until December 30, 2015. This extension will help providers and hospitals better understand the criteria needed to be accepted for less than two midnight inpatient stays by the time the MACs and the RACS again start to function.

Conclusion

SHM appreciates the opportunity to provide comments on the proposed 2016 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems. If we may provide any additional information on SHM or hospitalists in general, please do not hesitate to contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert Harrington, Jr.", with a stylized flourish at the end.

Robert Harrington, Jr., MD, SFHM
President, Society of Hospital Medicine