June 30, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services (CMS)
445-G Hubert H. Humphrey Building
Department of Health and Human Services
200 Independence Ave S.W.
Washington, DC 21201

Re: *Proposed Rule for Medicare Prospective Payment for Inpatient Hospital Operating and Capital for Fiscal Year 2015 (IPPS)*
CMS-1607-P

Dear Administrator Tavenner:

We are writing on behalf of the Emergency Department Practice Management Association (EDPMA) and the American College of Osteopathic Emergency Physicians (ACOEP) to comment on the Proposed Rule for Medicare Prospective Payment for Inpatient Hospital Operating and Capital for Fiscal Year 2015 (the Proposed Rule). Our comments focus on the development of an alternative payment methodology for short stays.

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused exclusively on the delivery of emergency medical services, with an emphasis on the provision of high-quality, cost-effective care in the Emergency Department. EDPMA's members include emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's Emergency Departments. **According to a 2013 report by the Rand Corporation, about half of hospital admissions come through the Emergency Department. And, EDPMA's members deliver (or directly support) health care for about half of the 130 million patients that visit U.S. Emergency Departments each year.**

The American College of Osteopathic Emergency Physicians (ACOEP) represents over 3000 Emergency Physicians and provides oversight to 45 Emergency Medicine Residency Programs. ACOEP, founded in 1975, exists to support high quality emergency care, promote and protect the interests of Osteopathic emergency physicians, ensure the highest standards of postgraduate education, and provide leadership in research through the Foundation for Osteopathic Emergency Medicine, in a distinct unified profession.

I. PRINCIPLES FOR ANY SHORT STAY PAYMENT METHODOLOGY

The Proposed Rule seeks comment on developing an alternative payment methodology for short hospital stays and also requests comment on changes to the current two-midnight payment rule. We appreciate that CMS, as a responsible payer and administrator of government funds, must ensure that Medicare payment methodologies are not manipulated or 'gamed' to inappropriately increase revenues to hospitals or providers, nor unintentionally penalize Medicare beneficiaries, nor produce an unsustainable future for the Medicare program.

Whether or not some version of the two-midnight rule is retained, we believe that a there is a core set of general principles that should apply to any short stay payment methodology. We believe that adherence to such principles will help address inherent tensions in any structure that attempts to establish and manage fair payment policies that meet the needs of the Medicare program, providers, and beneficiaries. The principals that we believe should be followed include:

1. Any new payment methodology should avoid setting arbitrary time-bound standards (e.g., 24 hours, 48 hours, two midnights, 3 days of hospitalization prior to admission to a skilled nursing facility, etc.). Such arbitrary, time-bound methodologies inevitably drive an undue proportion of nonsensical approaches by providers, patients, and hospitals in an attempt to comply with the method. Even though the care in the hospital may be similar, patients are concerned that their payment responsibility will be significantly different under the current rule that distinguishes "outpatient" and "inpatient" care. In our view, arbitrary and generalized time-bound methodologies are inconsistent with the complex and dynamic realities inherent in high-quality patient care, including age, co-morbidities, risk-adjustment factors, the availability of additional resources, and others. The inevitable result is an inordinate number of exceptions and unintended consequences.

2. Payment for the stay should be based on the patients' acuity, the severity of the patient's illness or condition, and/or the intensity of services and resources required to treat the patient. CMS should consider developing clear criteria for the level of care that is appropriate, instead of using the length of time a patient needs for hospital-based care.

3. Payment policy should recognize and account for the important and difficult reality that physicians must make decisions based on evolving, imperfect information about the patient's current and evolving diagnoses, health status and near-term needs. (We believe this situation is similar to physician decisions regarding patient eligibility for Medicare's hospice benefit.)

4. A stay that is ultimately found to be a "short" stay (i.e., a stay shorter than the average inpatient stay) should not be treated as an "outpatient" stay, with its attendant payment implications.

5. If implemented, beneficiaries should not be adversely affected by a short stay policy in combination with other rules or elements of the payment system. (For example,

beneficiaries should be able to count time spent in outpatient observation toward the 3-day inpatient requirement for skilled nursing care.)

6. Any new payment methodology should recognize that "one size does not fit all" and should meaningfully account for naturally-occurring outliers. (CMS has recognized the need for outlier policies in a number of other payment situations, such as DRG outliers, for example.)

7. While there should be provision for safeguards and prevention of abuse, general payment policies should not be established primarily to deter narrow instances of abusive practices.

8. Payment policies for hospital-based care should be neutral with respect to the hospital-based site of care whenever possible.

   Physicians in today's modern hospital Emergency Department (an outpatient setting) frequently deliver patient care at a level of intensity similar to hospital inpatient care provided a decade ago. The typical hospital Emergency Department provides rapid diagnosis, rapid results, and rapid access to specialists. The services provided in an Emergency Department often avert a hospitalization OR take the place of an observation stay or an admission. Frequently, patients cannot obtain these important services from their primary care physician, and may not be able to access needed services efficiently in other areas of the health system (or on their own).

   Long term, CMS should consider discontinuing distinctions such as "inpatient" and "outpatient" and consider using more useful distinctions - such as the need for hospital-based care, which should include patient care provided in an inpatient unit, an ICU, a hospital-based "short stay," and care provided in a hospital-based Emergency Department.

9. Any new short stay payment methodology should incorporate, or at least be integrated with, other payment policies such as outpatient reimbursement policies applicable in the Emergency Department.

10. The reimbursement methodology should encourage safe, efficient, and effective care.

We believe short stay methodology – or changes made to the two-midnight rule - should be consistent with all of these general principles.

We also have set forth below our comments on the particular questions CMS posed in the Proposed Rule.

II. TWO-MIDNIGHT RULE

A. General Concerns About the Two-Midnight Rule

The two-midnight rule, as it is currently being interpreted, has many flaws. The required certifications ask for the physician's educated guess of how long a patient is likely to stay in the hospital. As an arbitrary standard, it is applied in an inconsistent manner. As a result, hospitals

are paid very different reimbursement rates for treating patients with the same condition, who received the same treatment, and remained in the hospital for the same amount of time.

Due to the arbitrary nature of the rule, the two-midnight rule has resulted in a very high number of RAC audits. And, as evidenced by the number of cases overturned on appeal, many of these audits were unjustified.

In order to avoid the incredibly high number of RAC audits, hospitals are more likely to place patients in observation status even when the patient might require a multiday stay. This has led to the perverse result that, in practice, observation no longer appears to meet the CMS's own definition of "observation." The Office of the Inspector General raised concerns (in its July 2013 report on Hospitals' Use of Observation and Short Inpatient Stays for Medicare Beneficiaries) that there is rarely a sound clinical reason for a prolonged observation stay.

This overuse of observation status not only harms hospitals and providers, it can reduce the patients' access to care and increase the patients' out-of-pocket expenses. Patients face a delay in receiving skilled nursing care because their days in outpatient "observation" do not count toward the required three days of inpatient care needed to qualify for skilled nursing care. Medicare beneficiaries also become responsible for higher out-of-pocket costs under Part B. The Office of the Inspector General urged CMS to consider allowing patients to count time in observation toward the requirement for skilled nursing care.

Recommended Improvements to the Two-Midnight Rule

In the Proposed Rule, CMS noted that it has already identified a few rare occasions when inpatient care is appropriate even when there is no expectation of a two-midnight stay. We believe that, in the short term, prior to the adoption of new payment policies for "short stays," CMS should consider adopting an approach that would be more geared toward the resource utilization required to address the patient's condition. While elements of time are involved in diagnosis and treatment, the most significant issues are the level of care and resources required to address the patient's illness. In addressing the current, significant flaws in the current two-midnight rule, we highly recommend that the principles noted above be considered and obeyed.

An example of one practical option for substantive change is included in Attachment A.

III. DEVELOPING SHORT STAY PAYMENT METHODOLOGY

A. Need to Develop a New Payment Methodology for Short Stays

As discussed above, the current two-midnight policy has serious flaws. Moreover, healthcare surrounding a short stay remains fragmented and disconnected. Information is often lost. And providers often don't have complete information which leads to conflicting and duplicative care. The system is not designed well for care coordination. The current approach does not address this situation nor does it inherently encourage physicians, hospitalists, and other hospital-based physicians to communicate with each other, the primary care physician, or palliative care specialists. The two-midnight rule does not properly recognize the hospital-based physicians' role in a short stay. Accordingly, a short stay payment policy developed with the principles noted above will be a much better approach.

B. Emergency Physicians Must be Included in the Development of Short Stay Payment Methodology

Emergency physician groups are particularly well situated to play an important role in improving care provided in a short stay whether it is part of an inpatient or outpatient stay. A 2013 Report by the Rand Corporation entitled "The Evolving Role of Emergency Departments in the United States," (the "Rand Study") finds that Emergency physicians are major decision makers in about half of hospital admissions and are critical partners in helping hospitals meet their statutory obligations to provide emergency care without regard to ability to pay (EMTALA). And EDPMA members are involved in about half of the 130 million patient visits to the Emergency Department each year.

We encourage you to develop a payment approach for short stays that encourages the hospital and hospital-based physicians – including Emergency physician groups -- to work together to reduce duplicative testing and duplicative care and to improve communication, care coordination, and early detection during a short stay. The policy must recognize that physician communication and collaboration is particularly important during a short stay.

We also believe that any new short stay inpatient payment methodology should address physician reimbursement incentives. For instance, hospital-based providers should receive financial incentives for improving communication, care coordination, and transitional care during a short stay. The failure to acknowledge the important role of Emergency physician groups and other hospital-based physicians who are an integral part of a short stay may promote additional admissions, more use of advanced imaging, and sub-optimal care coordination, ultimately adding cost to the Medicare program without proportionate benefit for health care outcomes. Conversely, inclusion of the Emergency Department – and Emergency physician reimbursement - in incentives promotes judicious hospital admissions, timely consideration of alternatives to hospital admission, prudent coordination of care with primary and specialist physicians, and less episodic care that is relatively disconnected with the greater healthcare delivery system.

We also urge CMS to develop the short stay payment approach in coordination with developing general Medicare physician payment alternative payment methodologies that may apply to hospital-based physicians in the future. In response to a request from Congressional Committees regarding developing alternative payment models, EDPMA encouraged developing a model that would allow one or more specialties of hospital-based physicians and/or subsets of physicians and other providers of care to separately or jointly create an entity or a risk sharing/gains sharing mechanism to integrate the care delivered (and share responsibility for the financial risk) for the particular "care episode" around a hospital admission or outpatient alternative. Such an approach could encourage hospital-based physicians (such as emergency physicians, hospitalists, intensivists, surgeons) to collaborate to address quality, patient satisfaction and performance metrics for care provided during this critical period. This mechanism could also be used to permit such physician groups to collaborate with other providers in the community such as providers of post-acute care (e.g., SNFs, HHAs).

We believe such cross-provider integrated approaches promote accountability and value, but may be more flexible and targeted than the larger risk-taking approaches which are being arranged

through Medicare's current Shared Savings Program (ACOs). Any new short stay inpatient payment policy should also align with APMs under development that impact short stays.

C. Defining "Short Stay"

As discussed in our recommended set of principles, we believe that, instead of basing reimbursement on arbitrary time parameters, reimbursement should be based on clinical judgment, severity of the injury or illness, intensity of services, and the need for hospital-based care.

IV. CONCLUSION

We appreciate your interest in improving the reimbursement methodology for short stays. We urge you to ensure that reimbursement methodology for short stays is based on the principles laid out in Section I. If you decide to retain the two-midnight rule, we urge you to improve it as discussed in Section II. And we urge you to ensure that the short stay reimbursement policy is developed with input from Emergency Department physician groups, includes incentives for hospital-based physicians (who often are not hospital employees) and is developed in coordination with alternative payment models (APMs) developed for hospital-based physicians who are the major decision makers in a short stay as discussed in Section III.

In addition, we support the comments on the Hospital Readmissions Program and the Inpatient Quality Reporting Program that were submitted by the American College of Emergency Physicians.

Please feel free to contact Elizabeth Mundinger, Executive Director of EDPMA, with any questions at emundinger@edpma.org.

Sincerely,

James A. Kolka, D.O., FACEP
Chair, EDPMA Board of Directors

Mark Mitchell, DO, FACOEP
President, ACOEP

Attachment A

CMS created the MS-DRG to have a more accurate measure of resource utilization. We believe that this approach could be expanded to further improve accuracy in pricing short inpatient stays. We recommend three modifications to the current process all using currently available data elements in the CMS Form 1450 also known as the UB-04 or the electronic equivalent. These claims process modifications should reduce the high number of false positives tagged by RACs and lead to more appropriate reimbursement for a more accurately described patient condition. Such an approach should provide the MAC with better data to further refine their Grouper and Pricing algorithms.

i. For example, claim filing instructions for inpatient claims of less than two midnights could be modified to capture more information needed to describe the medical necessity of the admission. These simple changes to how data is provided on the claim should paint a much more accurate picture of why the admission was necessary and beneficial for the patient

1. Using the existing CMS Form 1450, for claims for stays under two midnights, the provider should include:
    a. Field 69: Admitting Diagnosis
    b. Field 70 A: Complication/Comorbidity
    c. Field 70B: Complication/Comorbidity
    d. Field 70C: Complication/Comorbidity
2. The instructions should instruct the provider to list the complications/comorbidities in order of highest to lowest contributing clinical reason for the admission.
3. The provider should be encouraged to report complication codes that describe severe abnormal vital signs or other severe abnormal diagnostic results in fields 67 B - Q.

ii. FI/MAC Grouper and Pricer process for short stays under two midnights:

1. Grouper should sort and process separately inpatient claims with a short stay admission under two midnights;
2. Grouper should incorporate the data described in fields 70A – 70C described above to assign the MS-DRG; and

3. The Grouper should add additional MS-DRGs based on analysis of the new data provided in fields 70A – 70C;

4. The Pricer Program could compare the LOS to average LOS based on the MS-DRG assigned and determine if a claim is an outlier;

5. The Pricer Program could designate short stay admissions under two midnights that are over or under the average LOS; and

6. The Pricer Program could refer short stay admissions under two midnights where the LOS is below the average LOS (outliers) for medical record review.

iii. The RACs should only review short stay admissions referred to them by the FI/MAC.

1. Claims data has been proven incomplete for determining whether an admission could have been handled as an outpatient visit; and

2. The FI/MAC's have more data and better analysis tools to determine outliers that may be indicative of an inappropriate admission.

This recommendation would be relatively easy to implement and should produce savings to providers and the Medicare program. This is not a complete solution but it offers a starting point for further refining ways to obtain and use claims data to more accurately analyze short stay admissions, in order to match patient care resources with patient care demand.